

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  02/25/2026
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 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on interview and record review the facility failed to develop a resident centered care plan with specific interventions for one of three sampled residents (Resident 1) to address behaviors of wandering into other resident' rooms. This deficient practice had the potential to compromise the safety, privacy and dignity of other residents and increased the risk for resident - to resident altercations and psychosocial distress. During a review of Resident 1's admission Record (AR), the AR indicated the resident was originally admitted to the facility on [DATE], with a diagnosis of dementia (condition that causes problems with memory, thinking, and decision - making that are severe enough to affect daily life) with behavioral disturbance, anxiety disorder ( a condition where a person feels excessive worry, fear, or nervousness that doesn't go away and interferes with daily life) , vascular dementia (parts of the brain don't get enough oxygen and nutrients because of strokes or damaged blood vessels) , and confusional arousals (the person wakes up but their brain hasn't fully turned on yet. They may not know where they are, may say strange things, act agitated, or seem frightened) . Durina a review of Resident 1' s Minimum Data Set ( MDS - care screening tool) , dated 1/22/2026, the MDS indicated Resident 1's cognitive skills ( mental action or process of acquiring knowledge and understanding for daily decision - making) are severely impaired and requires moderate assistance where the helper does more than half the effort for activities such as eating, toileting hygiene, dressing, and personal hygiene. The MDS was not coded as wandering in a manner that significantly intruded on the privacy or activities of others. During a review of Resident 1's progress notes titled Interdisciplinary Team ( IDT) note dated 02/09/2026, the Note indicated Resident 1 was involved in an altercation with a roommate 02/08/2026. The IDT indicated Resident 1 had a known cognitive impairment and was disoriented to time and place and ambulated independently to roommates' s bedside and attempted to pull up the roommates' blanket, entering the roommates' Personal space. The IDT indicated roommate became verbally upset and hit Resident 1 on the left eye. During a review of Resident 1's Initial psychiatric assessment dated 02/12/2026, the assessment indicated Resident 1 was profoundly confused, with severely impaired orientation and limited insight, which indicated Resident 1 functioned at an extremely low cognitive level, consistent with advanced dementia and did not demonstrate understanding of boundaries or the seriousness of certain behaviors. During an interview on 02/27/2026 at 10:30 AM with Social Service Director (SSD), SSD stated Resident 1 has a diagnosis of dementia with a low Brief interview for Mental (BIMS score - a tool used in skilled nursing facilities to assess a resident's mental abilities). SSD stated Resident 1 could not answer simple questions such as Resident 1's name and time. SSD stated Resident 1 required staff redirection since Resident 1 always wandered to other residents rooms. During an interview on 02/24/2026 at 10:40 AM with Registered Nurse (RN) 1, RN1 stated Resident 1 was very confused and wandered into other resident's rooms. RN 1 stated Resident 1 required redirections since Resident 1 always wandered into both female</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:  055899	Facility ID:  055899  If continuation sheet Page 1 of 4

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>and males rooms. RN 1 further stated there was no indication on the care plan for interventions to address Resident 1's wandering behaviors. During an interview on 2/24/2026 at 11:47AM with Registered Nurse ( RN) 2, RN 2 stated Resident 1 was confused and wandered into other resident's rooms. RN 2 further stated there were no specific interventions in place and no staff member assigned to monitor Resident 1's wandering behavior. RN2 stated complaints had been received from a couple of female residents regarding Resident 1s wandering into their rooms During a concurrent interview and record review on 2/24/2026 at 2:45 PM with minimum data set coordinator (MDSC), Resident 1's Care plans were reviewed. MDSC there was stated no care plan had been developed to address Resident 1's wandering behavior, specifically entering other residents' rooms, and there were no individualized interventions in place to address Resident 1's wandering behavior, the MDS Coordinator stated a care plan should have been initiated to guides staff on how to manage and provide care for Resident 1 During a review of the facility's policy and procedure titled, Care Plans, Comprehensive Person - Centered, dated December 2016, indicated A comprehensive, person- centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident. It should include an assessment of the residents' strengths and needs, identifying problem areas and their causes, and developing interventions that are targeted and meaningful to the residents.</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observation, interview, and record review, the facility failed to implement enhanced barrier precautions (EBP, extra protective steps staff use during hands- on care to prevent the spread of germs) as ordered by Physician on 11/18/2025 for one out of three sampled residents ( Resident 3). This deficient practice of not implementing physician's orders had the potential to result in the spread of infectious bacteria or other disease - causing organisms to other residents and staff, development of healthcare - associated infections, worsening of existing wounds, sepsis, and possible hospitalization. During a review of Resident 3's admission Record(AR), the AR indicated the resident was readmitted to the facility on [DATE] with diagnoses of but limited to a Urinary Tract infection ( UTI - infection in the bladder) , Pneumonia( infection of the lungs) , and sepsis( life -threatening condition that happens when the body's reaction to an infection spread through the bloodstream damaging organs. It can cause confusion, low blood pressure, trouble breathing, and can be fatal). During a review of Resident 3's History and Physical(H&amp;P) dated 06/24/2025, the H&amp;P indicated Resident 3 has the capacity to understand and make decisions. During a review of Resident 3's Minimum Data Set (MDS - Comprehensive assessment and screening tool) dated 12/18/2025, the MDS indicated the resident was moderate cognitive impairment. Meaning has some memory or recall difficulty and may need cueing, with possible safety awareness and is totally dependent on helpers for all activities of daily living ( ADL's). During a concurrent interview and record review on 2/25/2026 at 9:15AM with Licensed vocational Nurse (LVN) 2, Resident 3's Order Summary , dated 11/18/2025 was reviewed. The Report Indicated to continue EBP for infection control. LVN 2 stated an EBP sign should have been posted and personal protective equipment(PPE- equipment used to prevent or minimize exposure to hazards) should have been provided for staff to wear when providing care to Resident 3. LVN 2 stated it was important to implement physician orders to ensure residents and visitors were aware of what protective equipment to wear to limit the transmission of any infection. During a review of Resident 3's Individualized Care plan focused care plan nursing Diagnoses dated 02/17/2026 , indicated Resident 3 was at risk for infection related to multiple lower pressure injuries (open wounds that happen when someone stays in one position too long) , impaired skin integrity( skin that may have a tear, or wound) , at risk for catheter - Associated urinary tract infection ( CAUTI) related to presence of indwelling urinary catheter and at risk for transmission of Multi- Drug Resident Organisms ( MDROs) related to extensive wound care needs and presence of invasive devices. The Care plan goals indicated the compliance with Enhanced Barrier Precautions to be maintained by all staff to prevent cross- contamination with interventions to include clinical Surveillance. During a review of Resident 3's care plan titled Risk for Healthcare - Associated infection ( HAI) Related to the presence of a high- risk factor ( indwelling device, chronic draining wound, or multi-drug resident organisms (MDRO) colonization, as evidenced by the mandatory initiation of Enhanced Barrier Precautions ( EBP ) dated 11/20/2025, the Care plan indicated a goal for all direct care staff to demonstrate and document 100% compliance with EBP protocols ( Clean gown and gloves) During all high - contact care activities per facility audit checks and to meet Centers for Medicare &amp; Medicaid Services (CMS) standards. During a concurrent observation and interview on 02/24/2026 at 12:28PM with Certified nursing assistant ( CNA) 1 in Resident 3's room, CNA 1 was observed touching Resident 3's blanket without wearing personal protective equipment ( PPE), repositioning Resident 3's Foley catheter (a flexible, indwelling tube inserted through the urethra into the bladder to drain urine into a bag, held in place by a small, water-filled balloon) bag and, assisted Resident 3 without wearing without wearing PPE. CNA 1 did not know that Resident required PPE since</p> <p>(continued on next page)</p>		

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