| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 055899 | A. Building<br>B. Wing | 05/20/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Royal Palms Post Acute | 630 W. Broadway<br>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 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide appropriate treatment and care according to orders, resident?s preferences and goals.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to assess and monitor in accordance to the facility's policy and procedures and professional standard of practice for one of three sampled residents (Resident 1) who was readmitted to the facility and transferred to a Board & Care (B&C) by failing to: Ensure Registered Nurse (RN) 1 assessed and monitored Resident 1's condition by checking the blood pressure (BP), heart rate (HR), respiratory rate (RR), oxygen saturation level, and pain level and documented in Resident 1's clinical record when resident was readmitted to facility and transferred to a B&C.Ensure RN 1 conducted a full head to toe assessment when Resident 1 was readmitted to facility and transferred to a B&C.Ensure RN 1 notified Resident 1's responsible party to inform them of Resident 1's readmission to facility and transfer to B&C. These deficient practices increased the risk of Resident 1 not being accurately assessed for any changes of condition upon readmission and transfer.Findings:During a review of Resident 1's admission Record (AR), the AR indicated the resident was readmitted on [DATE] with diagnoses that included acute and chronic respiratory failure with hypercapnia, unspecified inflammatory spondylopathy (lumbar region,), and acute respiratory failure with hypoxia. During a review of Resident 1's History and Physical Assessment (H&P), dated 3/12/2026, the H&P indicated the resident was alert and oriented to person (know who they are), place (know where they are), and time (has a general sense of time, e.g. the correct day, month, or year). During a review of Resident 1's Minimum Data Set (MDS - a resident assessment tool), dated 3/2/2026, the MDS indicated the resident had moderately impaired cognition (the mental action or process of acquiring knowledge and understanding through thought, experience, and the senses). During a review of Resident 1's Order Summary Report, the report indicated the following physician orders:On 5/14/2026, an order to re-admit Resident 1 to the facility and then to discharge Resident 1 to a B&C.On 5/14/2026, an order to discharge Resident 1 from the facility to a B&C. During a review of Resident 1's electronic medical chart, the chart did not indicate an admission assessment, vital signs, nursing progress notes, discharge/transfer summary were documented/completed during the duration of Resident 1's stay at the facility. During an interview with the Director of Nursing (DON) on 5/20/2026 at 11:39 AM, the DON stated during the process of admission, the nurse who is admitting the resident should conduct and document an assessment of the resident. The DON stated the nurse should review the discharge papers from the General Acute Care Hospital (GACH) which includes discharge medications and discharge instructions and appointments. The DON stated the nurse would notify the resident's Physician when the resident arrives to the facility and reconcile the medications and orders from the GACH with the resident's Physician to input into the electronic medical record. The DON stated after review of GACH discharge papers with the Physician the nurse would ask if they wanted to include any additional orders. During the same interview on 5/20/2026 at 11:40 AM with the DON, the DON stated when a resident is transferred or discharged from the facility, there must be a Physician's order for where the resident's destination would be. The DON stated the nurse should communicate and endorse to the staff of the receiving facility that Resident 1 would be transferred to. The DON stated the nurse should complete a discharge summary, assessment, notification of transfer/discharge to the ombudsman, Physician, and resident's responsible party. The<br>(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 |
|---|---|---|

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 055899 | A. Building<br>B. Wing | 05/20/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Royal Palms Post Acute | 630 W. Broadway<br>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 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | DON stated the purpose of conducting and documenting assessments on admission, transfer and discharge was to check if resident was stable for transfer and make sure resident had no issues. The DON stated he was not sure what time Resident 1 arrived at facility on 5/14/2026 and when Resident 1 transferred to the B&C. The DON stated he could not recall how long resident was in the facility on 5/14/2026 for readmission. During a telephone interview on 5/20/2026 at 12:08 PM, Discharge Planner (DP) stated on 5/14/2026 stated there were no open female beds at the facility at the time. DP stated Resident 1's family was provided referrals to several places to accommodate resident's needs. DP stated based on Resident 1's clinical information, they were able to find a B&C that accepted Resident 1. DP stated Resident 1's family was upset because they wanted resident to stay at the facility, but there were no female beds available. DP stated Resident 1 was out of the facility for 30 days and usually when the resident is out of the facility for more than 30 days it was considered a discharge from the facility. During a telephone interview with RN 1 on 5/20/2026 at 12:24 PM, RN 1 stated she received instruction from the Social Services Director (SSD) to readmit Resident 1 and transfer to B&C since transportation was already set up by the facility. RN 1 stated Resident 1 arrived at the facility on 5/14/2026 at around 5:30 PM and was at facility for about an hour. RN 1 stated when a resident arrives from GACH, whoever the admitting nurse is should review the discharge medication list for medication reconciliation, discharge summary and instructions and H&P. RN 1 stated Resident 1 arrived with the discharge documentation from the GACH, but she did not review any of the documentation. RN 1 stated she checked on Resident 1 when she arrived, checked her vital signs and did not document her findings. RN 1 stated she attempted to conduct a skin and body assessment, but Resident 1 refused. RN 1 stated she did not document any of her encounters with Resident 1 while she was in the facility for that one hour. RN 1 stated there should be an assessment and she should have documented before Resident 1 was transferred, but because of instruction from the SSD of readmitting the patient and pick up for the patient in 1 hour, I did not do it. RN 1 the purpose of an assessment was to check if there were any skin issues, wounds, or any other issues. RN 1 stated she did not document anything. RN 1 stated if there were any abnormalities on assessment something could happen with resident and whoever was receiving the resident would report us. During an interview with the DON on 5/20/2026 at 12:43 PM, the DON stated the expectation of the licensed nurses was to conduct and document assessments for admissions, transfers, and discharges. The DON stated RN 1 should have taken instruction from himself and not the SSD. The DON stated because Resident 1 was readmitted , RN 1 should have done the complete admission and discharge process. A review of the facility's policy and procedure (P&P) titled Transfer or Discharge Documentation, dated 12/2016 indicated when a resident is transferred or discharged , details of the transfer or discharge will be documented in the medical record and appropriate information will be communicated to the receiving health care facility or provider. The P&P indicated when a resident is transferred or discharged from the facility, the following information will be documented in the medical record:The basis for the transfer or discharge;If the resident is being transferred or discharged because his or her needs cannot be met at the facility, documentation will include:the specific resident needs that cannot be met;this facility's attempt to meet those needs; andthe receiving facility's service(s) that are available to meet those needs.2. That an appropriate notice was provided to the resident and/or legal representative;3. The date and time of the transfer or discharge;4. The new location of the resident;5. The mode of transportation;6. A summary of the resident's overall medical, physical, and mental condition;7. Disposition of personal effects;8. Disposition of medications;9. Others as appropriate or as necessary; and10. The signature of the person recording the data in the medical record. |