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	06/01/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Royal Palms Post Acute	630 W. Broadway Glendale, CA 91204

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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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure informed consent (the process in which a healthcare professional explains the risks, benefits, and alternatives of a procedure to a person, ensuring they fully understand it before agreeing to participate was obtained prior to the use of psychotropic medications for one of two sampled residents (Resident 2) in accordance with the facility's policy and procedure (P&P) titled Informed Consent for Psychotropic Drugs. This deficient practice had the potential to violate resident' rights to be informed prior to administering medications without their knowledge or approval. This also placed the resident at risk for unnecessary chemical restraint (the use of medication to intentionally slow down, sedate, or control a person's movements and behavior) that limit their ability to participate in care decisions.Findings: During a review of Resident 2's admission Record (AR), it indicated, Resident 2 was originally admitted to the facility on [DATE] with diagnoses that included schizoaffective disorder (a mental illness that can affect thoughts, mood, and behavior), mood disorder (a mental health condition that affects emotional state and it causes extreme mood swings), mental disorder (a medical condition characterized by significant changes in a person's thinking, mood, or behavior), and anxiety (a mental health condition characterized by excessive, persistent and uncontrollable fear or worry). During a review of Resident 2's History and Physical (H&P) dated 4/1/2026 it indicated that Resident 2 had the ability to understand and make basic decisions, need some help with more complicated healthcare related decisions. During a review of Resident 2's Minimum Data Set (MDS - a resident assessment tool) dated 4/6/2026, indicated Resident 2 cognition (the ability to process thoughts) was severely impaired. During a review of Review of Resident 2's Physician Order Report dated 3/30 2026 to 5/29/2026 indicated to give Resident 2 the following: a. valproic acid (a prescribed medication used to stabilize severe mood swings in bipolar disorder [sometimes called manic-depressive disorder; mood swings that range from the lows of depression to elevated periods of emotional highs]) oral capsule 250 milligrams (mg- metric unit of measurement, used for medication dosage and/or amount) give 3 capsule by mouth four times a day for recurrent behavior fluctuations from calm to manic behavior and vice versa as evidence by sudden outburst anger with screaming and yelling dated 3/30/2026. b. Seroquel (is a medication that treats schizophrenia (a mental illness that is characterized by disturbances in thought) and bipolar disorder) oral tablet 100 mg give 3 tablets by mouth at bedtime for sudden outbursts of anger dated 3/31/2026. c. Ativan (is a medication used to treat anxiety disorders or anxiety) oral tablet 1mg give one tablet by mouth every 12 hours as needed for anxiety for 14 days manifested by outburst of anger as evidence by disorganized behavior with attempt to strike out when receiving care dated 4/30/2026. During a review of Resident 2's Psychotherapeutic Drug Informed Consent Form dated 3/31/2026, indicated for the informed consent for Seroquel, valproic acid, (Ativan) lorazepam (Resident 2's cognition was severely impaired)was not signed by the physician. The consent for Ativan indicated for the dose of 0.5 mg and it did not have the consent for 1 mg that was ordered on 4/30/2026. During a concurrent interview and record review of Resident 2's Psychotherapeutic Drug Informed Consent Form on 5/30/2026 at 3:40 PM Social Services Director (SSD) stated, Resident 2's cognition status varied from time to time and the (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	resident was assessed to have impaired cognition and therefore the resident cannot sign the inform consent. SSD understands that the Interdisciplinary team (IDT - a coordinated group of experts from several different fields who work together) should have intervene with decision making since Resident 2 did not have the capacity to make decision for self and there was no designated family or resident representative to make the decision on behalf of the resident. SSD stated the facility only had three consents for Resident 2 and none for Resident 1's Ativan 1 mg. During a review of the facility's P&P Informed Consent for Psychotropic Drugs undated, it indicated, inform consent must be obtained for all psychotropic medications prior to initiation or a dose increase. The policy indicated for residents that lack capacity to make decisions and are without a representative follow state-specific procedures such as ethics committee (a group of people from different backgrounds who review rules and tough choices to make sure things are done fairly and safely), court appointment.

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to prevent a physical abuse (a type of abuse that uses physical force) one of two sampled resident (Resident 1) when: The facility did not follow physician order to send Resident 2 to the General Acute Community Hospital emergency room for psychiatric evaluation on 4/30/2026. Certified Nurse Assistant (CNA 1) left Resident 1 alone with Resident 2 (Resident 1's roommate) after Resident 2 had attempted to hit Resident 1 on 5/28/2026. CNA 1 did not separate Resident 2 from Resident 1 when Resident 2 was actively hitting Resident 1 with the water pitcher on 5/28/2026. The facility failed to address and accommodate Family 1 (FM 1-Resident 1's family) verbalized to the Interdisciplinary team (IDT - a coordinated group of experts from several different fields who work together) and to Social Services concerns of Resident 1's safety with the roommate (Resident 2) and had requested a room change since 5/25/2026. These deficient practices resulted in Resident 2 hitting Resident 1 with a water pitcher which may cause serious injury and psychosocial harm to Resident 1. Findings: During a review of Resident 1's admission Record, the admission Record indicated the facility originally admitted Resident 1 on 5/22/2026, with diagnoses that included compression fracture (break in a vertebra [spine bone]) of thoracic (T-upper middle back) 7 & T8 Vertebra, wedge compression fracture (two bones have cracked and collapse) of T11 & T12 vertebra, difficulty walking, and muscle weakness. During a review of Resident 1's History and Physical (H&P) dated 5/23/2026, it indicated Resident 1 had the ability to understand and make healthcare decisions. During a review of Resident 1's Care Plan dated 5/25/2026, it indicated Resident 1was at risk of injury, fractures, decreased mobility and that resident would remain free from falls and injury with interventions to report changes in condition promptly. During a review of Resident 1's IDT dated 5/28/2026 at 4:00PM, it indicated the altercation between Resident 1 and Resident 2 occurred in Resident 1 and 2's room. The IDT note also indicated Resident 1 had a pain level of 7/10 with decreased range of motion. During a review of Resident 1's Progress Notes (psychosocial notes) dated 5/28/2026 at 5:38 PM, it indicated Resident 1 complained that Resident 1 was hit on the right shoulder and right leg by roommate Resident 2 with the water pitcher. During a review of Resident 2's admission Record, it indicated that Resident 2 was originally admitted to the facility on [DATE], with diagnoses that included schizoaffective disorder (a mental illness that can affect thoughts, mood, and behavior), mood disorder (a mental health condition that affects emotional state and it causes extreme mood swings), mental disorder (a medical condition characterized by significant changes in a person's thinking, mood, or behavior), and anxiety (a mental health condition characterized by excessive, persistent and uncontrollable fear or worry). During a review of Resident 2's Minimum Data Set (MDS - a resident assessment tool) dated 4/6/2026, it indicated Resident 2 had active diagnoses of anxiety disorder, bipolar disorder, schizophrenia disorder, morbid obesity, and severe cognitive impairment (ability to think and reason). During a review of Resident 2's Order Summary Report it indicated a medication order dated 3/30/2026 valproic acid (prescribed medication to stabilize extreme mood swings)750 mg four times a day for mood disorder manifested by recurrent behavior of fluctuations from calm to manic (mental state of an extreme highs or depressive lows) behavior with sudden outburst anger with screaming and yelling. During a review of Resident 2's Multidisciplinary Care Conference dated 3/31/2026 it indicated, Resident 2 was recently in a psychiatric hospitalization (a temporary stay in a specialized hospital or hospital unit that provides care for mental illness) after setting the resident's room on fire and reporting suicidal ideation (suicidal thoughts or ideas centered around death) while expressing distress about the care received at the previous facility. During a review of Resident 2's Order Summary Report it indicated, Resident 2 had medication order dated 3/31/2026 for Seroquel (prescribed medication that is an antipsychotic to treat schizophrenia and bipolar disorder) 300 (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	milligrams (mg- metric unit of measurement, used for medication dosage and/or amount) at bedtime for schizoaffective disorder manifested by sudden outburst of anger. During a review of Resident 2's Nursing Progress Notes dated 4/29/2026 at 2:08 PM it indicated that Resident 2's Medical Doctor (MD 1) was notified of Resident 2 yelling in the hallway. During a review of Resident 2's Care Plan titled Impaired Emotional Regulation dated 4/29/2026, it indicated Resident 2 had sudden outbursts of anger, yelling and inability to control emotional responses related to Resident 2's psychiatric disorders. It also indicated interventions were to remove Resident 2 from stimulating environment and escort to quiet, safe area, and to provide one to one staff supervision (one staff designated to monitor or supervise the resident) during the episode. During a review of Resident 2's Nursing Progress Notes dated 4/30/2026 at 9:33 AM it indicated that MD1and Psychiatric Nurse Practitioner (PNP 1) gave order to send Resident 2 to GACH emergency room for further evaluation and management of behavioral outburst. During a review of Resident 2's Psychosocial/Social Services Note dated 4/30/2026 at 10:21 AM indicated that while in the dining room Resident 2 threw a food plate at the Administrator (ADMIN) and was using profanity. During a review of Resident 2's Nursing Progress Notes dated 4/30/2026 at 10:52 PM Resident 2 struck a CNA (not indicated who) on the chest while CNA was providing care to the resident. During an interview on 5/30/2026 at 4:01 PM with Assistant Director of Nurses (ADON) stated that there was no documentation in Resident 2's chart that Resident 2's MD 1 was made aware that Resident 2 was not transferred to the GACH emergency room (ER) as ordered on 4/29/2026. ADON also stated Resident 2 was not transferred to the GACH ER due to insurance issues. During an interview on 6/01/2026 at 10:40 AM, MD 1 stated since Resident 2 was not transferred to GACH due to insurance issued, the facility should have continued to make arrangement for the 5150 (psychiatric hospitalization). During an interview on 6/1/2026 at 10:53 AM with CNA 1, CNA 1 stated on 5/28/2026 approximately 3:10 PM soon after CNA 1 left Resident 1 and 2's room, CNA 1 heard screaming when he returned to the room, he saw the water pitcher on the floor and Resident 2 was trying to hit Resident 1. CNA 1 stated CNA 1 told Resident 2 to calm down, and CNA 1 left the room to get Resident 1 another pitcher of water. CNA 1 filled the water pitcher with ice water and placed it on Resident 2's overside table and left the room. CNA 1 stated about 2 minutes later he heard screaming and returned to the room to find Resident 2 hitting Resident 1 with the water pitcher on the right shoulder and that Resident 2 was complaining that Resident 1 had thrown water at her (Resident 1). CNA 1 stated Resident 1 was wet but does not remember Resident 2 being wet. CNA 1 stated he did not report it to the charge nurse because Resident 2 was calm and cooperative and did not see the need to report it. During an interview on 6/1/2026 at 12:05 PM with Licensed Vocational Nurse (LVN 1), stated that CNA 1 came running to her and told her, They (Resident 1 and 2) are fighting in Room A LVN 1 stated, LVN 1 told CNA 1 do not leave the Residents 1 and 2 alone in the room while having an altercation. LVN 1 stated it was the end of her shift and did not do an investigation or gather more information because it was time for LVN 1 to go home. During an interview on 6/1/2026 at 1:53 PM with FM1, FM 1 stated that FM 1 was not in the facility when the altercation between Resident 1 and 2 occurred. FM 1 stated FM 1 immediately drove to the facility after learning about the altercation between Residents 1 and 2 on 5/28/2026. FM 1 stated when she arrived at the facility there were FM 1 saw when Resident 1 was taken out of the room while Resident 2 was still yelling at Resident 1. FM 1 stated Resident 1 has been enduring loud noises such as yelling, singing, loud television sound, stated that Resident 1 would gesture Resident 2 to lower the television, but it would only get louder. FM 1 also stated, FM 1 requested the facility during one of the IDT meetings (unable to recall when) and social services multiple times verbalizing FM 1's concerns with Resident 2 and asked them to move Resident 1 out to another room since 5/25/2026 but stated nothing happened until 5/28/2026 the day of the incident. During an interview on 6/1/2026 at 4:50 PM with the Director of Nurses (DON), the DON stated that CNA 1 should have stayed in the room with the resident and immediately separated both Resident 1 and 2 on 5/28/2026. The DON stated when there is a verbal or physical altercation this episode should have been reported (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	immediately to the charge nurse, physician, and the DON stated that CNA 1 observed that Resident 2 was calm and cooperative, and CNA 1 thought everything was okay. During an interview on 6/1/2026 at 5:12 PM with the Administrator (ADMIN), ADMIN stated, when there is any type of verbal or physical altercation between the residents the policy should have been followed even when Resident 2 showed no signs of aggression. During a review of the facility's policy and procedure (P&P) Abuse Prevention, Reporting, Investigation, and Response Policy undated, it indicated, the facility is committed to providing a safe environment free from abuse and that all the residents have the right to be treated with dignity, respect, and protection from harm. The facility's policy indicated, part of their prevention of abuse is that staff would be educated to recognize signs and symptoms of abuse and that immediate measures will be implemented to protect residents from further harm. The policy indicated the facility would maintain an environment that promotes resident safety, dignity, and respect.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure one of four sampled residents (Resident 4) who was assessed as a high risk for pressure injury (a localized injury to the skin and/or underlying tissue usually over a bony prominence as a result pressure in combination with shear) received services to protect skin integrity (state of being intact, healthy, and free from damage), promote healing, and prevent development and worsening of pressure injury by failing to ensure toileting hygiene was done after Resident 4 had a bowel movement and not wait for one hour in accordance with Resident 4's care plan to keep skin clean and dry. This deficient practice had the potential to result in a delay in promoting healing of a pressure ulcer. Findings: During a review of Resident 4's admission Record (AR), it indicated Resident 4 was originally admitted to the facility on [DATE] with diagnoses that included pressure ulcer of right buttock, cerebrovascular accident (CVA-stroke, loss of blood flow to a part of the brain), and osteoarthritis (a progressive disorder of the joints, caused by a gradual loss of cartilage). During a review of Resident 4's Care Plan, titled Pressure Injury/Ulcer dated 3/12/2026, it indicated to keep skin clean and dry. During a review of Resident 4's Minimum Data Set (MDS - a resident assessment tool) dated 3/17/2026, the MDS it indicated, Resident 4 needed substantial/maximal assistance (helper does more than half the effort. Helper lifts or holds trunk or limbs and provides more than half the effort) with lower body dressing and partial/moderate assistance (helper does less than half the effort. Helper lifts, holds, or supports trunk or limbs, but provides less than half the effort) with putting on/taking off footwear, upper body dressing, toileting hygiene. The MDS also indicated Resident 4 needed supervision with oral and personal hygiene. It indicated Resident 4 is at high risk of developing pressure ulcers/injuries and was admitted to the facility with a stage 4 pressure ulcer (full-thickness skin and tissue loss with exposed muscle, tendon, ligament, cartilage, or bone) During a review of Resident 4's Care Plan, titled Resident is at Increased Risk for Recurrent Infection Due to Pressure Injury dated 4/6/2026, it indicated due to chronic illness and reduced mobility Resident 4 is at risk of infection with intervention to ensure timely wound care and hygiene. During a review of Resident 4's Wound Assessment dated 5/1/2026, it indicated right ischium/gluteal fold stage 4 pressure ulcer with a measurement of 4.0 centimeters in length (cm - unit of length used to measure) and 0.5 cm in width and 0.2 cm in depth with light serosanguinous (fluid or discharge that contains both blood and fluid). During an interview 6/1/2026 at 4: 20 PM with Resident 4, Resident 4 stated that when he has had episodes of bowel incontinence, he has used the call light (call system used in the healthcare facility for residents to alert staff when the resident needed help) to ask for assistance and has been left in bed soiled for long periods of time (resident cannot recall a specific date) and it is usually at night time. During a concurrent interview and record review on 6/1/2026 at 1:42 PM with Director of Staff Development (DSD), Resident 4's Nursing Progress Notes 5/27/2026 was reviewed. DSD stated according to the nursing progress notes that on 5/27/2026 at 10:00 AM Resident 4 had an episode of diarrhea (stool is loose, watery, and happens more often than usual). DSD stated that the Certified Nurse Assistant (CNA) assigned to Resident 4 provided toileting hygiene one hour after the bowel incontinence episode because per the CNA's task documentation on 5/27/2026 Resident 4 did not get toileting care until 11:05 AM. DSD stated staff are instructed to provide incontinent care as soon as possible to the residents to ensure residents are kept clean and dry and in order to prevent skin complications, including a decline in wound healing. During a review of the facility's P&P Call Light System Policy undated, it indicated, in order for residents to have a reliable method to request assistance, promote timely staff response the facility will maintain a call light system to allow residents to request assistance and communicate their needs safely and effectively. The P&P also stated that it is the facility's expectation that staff should respond promptly to all call light activations. During a review of the facility's P&P Pressure Wound Documentation, Consultant Review, and Care Plan Update Policy undated, it indicated, weekly (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interdisciplinary (IDT - a coordinated group of experts from several different fields who work together) should be completed for the resident by the IDT on a weekly basis to monitor for progression and healing status of wound, treatment effectiveness, nutritional and clinical risk factors, consultant and physician recommendations, need for additional interventions or services, and appropriateness of current care plans.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to administer continuous oxygen (O2) therapy (a treatment that provides you with supplemental, or extra, oxygen. The administration of O2 at concentrations greater than that in ambient air [20.9%] with the intent of treating or preventing the symptoms and manifestations of hypoxia [decreased perfusion of oxygen to the tissues] and respiratory therapy [services that are provided by a qualified professional such as respiratory therapists or respiratory nurse] for the assessment, treatment, and monitoring of residents with deficiencies or abnormalities of pulmonary function) as ordered by the physician for one of four sampled residents (Resident 5). This failure had the potential to put Resident 5 at risk of breathing difficulty including respiratory arrest (completely stop breathing) due to the lack of oxygen. Findings: During a record review of Resident 5's admission Record, the admission Record indicated Resident 5 was originally admitted to the facility on [DATE] and readmitted to the facility on [DATE] with diagnoses that included congestive heart failure (CHF-a heart disorder which causes the heart to not pump the blood efficiently, sometimes resulting in leg swelling), and chronic respiratory failure (a condition where there is not enough oxygen or too much carbon dioxide [natural waste odorless gas that humans breathe out]). During a record review of Resident 5's Minimum Data Set (MDS - a resident assessment tool) dated 3/26/2026, it indicated Resident 5's cognition (the ability to process thoughts) was intact. The MDS indicated Resident 5 had been on oxygen therapy in the last seven days lasting at least 15 minutes. During a review of Resident 5's Order Summary Report dated 5/30/2026, it indicated a physician order to administer continuous O2 at 2 to 5 liters per minute (LPM) via nasal cannula (a small plastic tube, which fits into the person's nostrils for providing supplemental oxygen) and titrate (adjust setting) O2 to maintain saturation (measure the percentage of oxygen-carrying hemoglobin in your blood) of more than 92%. During a review of Resident 5's Care Plan titled Resident Has Ineffective airway exchange and Respiratory Diagnosis/history of Pulmonary Edema dated 11/21/2025, the care plans indicated the goal that Resident 5 will have no respiratory distress and will maintain saturation above 92%. The care plan indicated intervention to provide supplemental O2 delivery Resident 5 on 2 LPM via nasal cannula. During an observation in Resident 5's room on 5/31/2026 at 5:23 PM, Resident 5 was observed with a nasal cannula connected to an empty portable oxygen cylinder (small metal tank that holds extra oxygen). Resident 5 complained of not getting enough oxygen. Resident 5's oxygen saturation was checked by Respiratory Therapist (RT) and it was noted to be 80%. During an interview on 5/31/2026 with Resident 5, Resident 5 stated he called for staff assistance because he noticed he was not getting enough oxygen and was having difficulty breathing. During an interview on 5/31/2026 with RT, RT stated the staff did not notify RT that Resident 5 was back in bed and that RT was responsible to reconnect Resident 5 to the oxygen concentrator (a medical device/ machine that draws in ambient air, removes nitrogen, and delivers concentrated oxygen up to 95% pure). During a review of the facility's policy and procedure (P&P) titled, Oxygen Administration dated 10/2010, it indicated while residents are receiving oxygen therapy the resident should be assess for the following signs or symptoms: restlessness, confusion, difficulty breathing, or slow rate of breathing including vital signs. The P&P indicated verify that there is a physician's order for this procedure review the physician orders or facility protocol for oxygen administration

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F 0825 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide or get specialized rehabilitative services as required for a resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to provide physical therapy, (a healthcare specialty focused on restoring movement, reducing pain, and improving overall function) five (5) times a week in accordance with the physician's order for one of two (2) sampled residents (Resident 4). This deficient practice had the potential to place Resident 4 at risk for decline in functional mobility. Findings: During a review of Resident 4's admission Record (AR), the AR indicated Resident 4 was originally admitted to the facility on [DATE] with diagnoses that included repeated falls, cerebrovascular accident (CVA-stroke, loss of blood flow to a part of the brain), and osteoarthritis (a progressive disorder of the joints, caused by a gradual loss of cartilage). During a review of Resident 4's Minimum Data Set (MDS - resident assessment tool), dated 3/17/2026, the MDS indicated Resident 4's cognitive (the ability to process thoughts) ability for daily decision making was moderately impaired. The MDS indicated that Resident 4 needed substantial/maximal assistance (Helper does more than half the effort. Helper lifts or holds trunk or limbs and provides more than half the effort.) with lower body dressing. Resident 4 needed partial/moderate assistance (Helper does less than half the effort. Helper lifts, holds, or supports trunk or limbs, but provides less than half the effort.) with putting on/taking off footwear, upper body dressing, toileting hygiene, rolling left and right, sitting to lying, lying to sitting on the side of the bed, sitting to stand, and chair/bed-to-chair transfer. During a review of Resident 4's Care Plan Resident Has Impaired Physical Mobility dated 4/6/2026, the Care Plan indicated Resident 4 has risks for falls with injury, further loss of mobility and independence, increased need for assistance with Activities of Daily Living (Activities of Daily Living (ADLs- routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves). The care plan interventions were to continue ordered rehab services for strengthening, gait training, and neuromuscular (hands-on-training to help the brain and muscles communicate better, and therapeutic activities (exercises that mimic daily movements) re-education. During a review of Resident 4's Order Summary Report dated 5/7/2026, the Order Summary Report indicated a physician order for skilled physical therapy every day 5 times a week for 4 weeks for therapeutic exercises, gait training (therapy designed to improve how to walk and stand), neuromuscular re-education. During a review of Resident 4's Physical Therapy Treatment Encounter Note (s), the Physical Therapy Treatment Encounter Notes indicated Resident 4 received an evaluation for physical therapy on 5/7/2026, and physical therapy treatments on 5/8/2026, 5/11/2026, 5/14/2026, and 5/20/2026. During a review of Resident 4's History and Physical (H&P) dated 5/25/2026, the H&P indicated that Resident 4 was admitted to the facility for skilled physical therapy services with the goal to improve balance, prevent falls, increase functional activity tolerance, increase coordination, and promote safety awareness. H&P also indicated that Resident 4 has a high risk of developing contractures (a stiffening/shortening at any joint, that reduces the joint's range of motion), pressure ulcers (localized, pressure-related damage to the skin and/or underlying tissue usually over a bony prominence) poor healing or fall if not receiving adequate therapy and that discharge planning was pending therapy progress. During an interview on 6/1/2026 at 1:14 PM, the Director of Rehabilitation (DOR) stated that Resident 4 has not been receiving physical therapy as ordered by the physician and Resident 4's physician has not been notified of lack of therapy treatments. The DOR stated they do not have adequate Physical Therapist coverage and are actively hiring. During an interview on 6/1/2026 at 4:15 PM, Resident 4 stated that he has not been receiving therapy as he knows he should. Resident 4 stated that he has only received physical therapy a few times and does not understand why he is not receiving it more frequently. Resident 4 stated that his personal goal is to return home, and his physician advised that physical therapy is necessary for him to regain the ability to care for himself safely and independently. During an interview on 6/1/2026 at 4:50PM, the Director of Nurses (DON) stated that the facility must inform (continued on next page)

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	06/01/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Royal Palms Post Acute	630 W. Broadway Glendale, CA 91204

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F 0825 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	the physician when there is an order that cannot be carried out. The DON added it is the facility's responsibility to ensure timely communication with physicians to prevent decline and maintain the well-being of the residents. During an interview on 6/1/2026 at 4:20 PM with Family Member 2 (FM 2), FM 2 stated that Resident 4 has been informing her that he is not receiving physical therapy and Resident 4 would like to go home. FM 2 stated the main purpose of Resident 4's stay at the facility is to receive physical therapy. During a review of the facility's undated Facility Assessment, the Facility Assessment indicated that therapy services such as physical therapy is needed to meet the needs of the resident population. The Facility Assessment indicated the necessity of having qualified staff members available to deliver these services and ensure residents receive appropriate care. During a review of the facility ?s policy and procedure (P&P) titled, Functional Impairment - Clinical Protocol, dated 3/2018, the P&P indicated that the facility staff and physician will collaborate to identify rehabilitative or restorative care plan to help improve function and quality of life and meet a resident/patient's goals and needs to attain desired outcomes such as discharge to the community. During a review of the facility's policy and procedure (P&P) titled, Guidelines for Notifying Physicians of Clinical Problems dated 2/2014, indicated that any change in physical condition or functional status that is not accompanied by debilitation or more than minimal distress.

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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 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facilityˆfailed toˆensure a safe and comfortable environment for one of two sampled residents (Resident 3) asˆindicatedˆon the facility policy by failing to provide resident with a comfortable and safe bed. ˆˆ This deficient practice resulted in Resident 3 experiencing discomfort which could negatively affect Resident 3's overall well-beingˆand quality of life.ˆ Findings: During a review of Residentˆ3's admission Record, the admission Record indicated Residentˆ3ˆwas originally admitted to the facility on [DATE] with diagnoses that included pneumothoraxˆ(collapse lung),ˆˆthoracic -1,2 vertebra (back bone, first two bones of the mid back, located at the base of the neck fracture [break in a bone]) fracture, multiple rib fractures of the right sideˆ1, 4 to 11, right shoulder scapula (shoulder blade) fracture, 4,5- lumbar vertebra fracture (lower back bone fracture), laceration of the liver, right acetabulum (large cup-shape socket on the side of the pelvis) fracture, right pubis fracture (break in one of theˆbones that makes the front of the pelvis), difficulty in walking, multiple facial bone fractures, and left acetabulumˆ left pubis fracture with bladder injury. During a review of Resident 3'sˆMinimum Data Setˆ(MDS - a resident assessment tool), datedˆ5/26/2026,ˆthe MDS indicatedˆResident 3 had intact cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decision making. Resident 3 requiredˆsubstantial/maximalˆassistance (helper does more than half the effort. Helper lifts or holds trunk or limbs and provides more than half the effort)ˆin shower/bathe self. Resident 3 required partial/moderateˆassistance (helper does less than half the effort. Helper lifts, holds, or supports trunk or limbs, but provides less than half the effort)ˆwith personal hygiene, putting on/taking off footwear, lower body dressing, upper body dressing,ˆandˆtoileting hygiene. During an observation and interview on 5/30/2026 at 11:40 AM in Resident 3's bedroom, Resident 3 stated that the bed was not comfortable, especially at night when his pain worsens. Resident 3 stated that the right corner of the bed had a metal piece used for supporting the corner of the mattress, but the left side was missing the left corner metal piece causing the mattress to tilt to the left side. Resident 3 further stated this misalignment caused him discomfort when lying in bed. Resident 3 stated that he had told facility staff how uncomfortable the bed was, but nothing was resolved. During a concurrent observation and interview on 5/30/2026 at 1:24 PM with Maintenance (MAINT 1), MAINT 1 assessed Resident 3's bed. MAINT stated the right metal corner on Resident 3's bed was missing the left side causing the mattress to tilt to the side. MAINT 1 stated that Resident 3 had told him about the mattress issue and had told Resident 3 that MAINT 1 was going to order another mattress that might take up to 2 weeks to receive. During a review of Resident 3's Care Plan titled, Acute Pain Related to Multiple Traumatic Fractures,ˆdated 5/21/2026,ˆthe Care Plan indicatedˆthatˆResident 3ˆwas at risk for sleep disturbance. Theˆpain goal was 3/10 during rest and activity. The care plan interventions were to assess pain every shift, administer analgesicsˆas ordered and reassess effectiveness, implement non-pharmacological interventions such as positioning, relaxation, environmentˆadjustment. During a review of the facility's Policy and Procedure (P&P) titled,ˆ Pain Assessment and Management, dated 4/2025, the P&Pˆindicatedˆto implement painˆmanagementˆstrategiesˆconsidering theˆresident'sˆmedical condition, current medication regimen and cause of the pain, course of the illness, and treatment goals. During a review of the facility's undated P&P titled, Preventive Maintenance of Equipment Policy, the P&Pˆindicatedˆthat the facility would ensure all facility equipment isˆmaintainedˆin safe working condition to support resident care, safety, and regulatory compliance.