

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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No. 0938-0391

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 07/29/2026
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)		
F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the transfer/discharge meets the resident's needs/preferences and that the resident is prepared for a safe transfer/discharge. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and records review, the facility failed to ensure a safe and appropriate discharge for one of two sampled residents (Resident 1), who left for an out-on-pass (OOP- temporary leave an admitted patient has official, temporary permission from their doctor to leave a hospital or care facility for a short, set amount of time before returning to finish treatment) on 7/27/2026 by failing to: Ensure Resident 1 signed out of the facility onto the out on pass log on 7/27/2026 in accordance with the facility's Policy and Procedure (P&P) titled, Signing Residents Out. Inform Resident 1 the clinical risks for discontinuing care at the facility in accordance with the facility's P&P titled, Discharging a Resident Against Medical Advice. Document the reason for the discontinuation of care for Resident 1 in accordance with the facility's P&P titled, Discharging a Resident Against Medical Advice. Provide information or arrangements regarding post discharge plan of care in accordance with the facility's P&P titled, Discharging a Resident Against Medical Advice. These deficient practices resulted in a facility-initiated discharge against medical advice (AMA) of Resident 1. After leaving for an OOP on 7/27/2026 at 10:30 PM and returning on 7/28/2026 at 2 PM (16 hours later), Resident 1 was left to stay at FM 1's home. These actions placed Resident 1 at risk for an unsafe transition of care, unrecognized changes in medical condition, interruption of necessary treatment, and inadequate continuity of care following discharge. Findings:During a review of Resident 1's admission Record (AR), the AR indicated Resident 1 was admitted to the facility on [DATE] with a diagnosis"stable burst"fracture of 4th"lumbar"vertebra"(break or crack in the 4th"bone of the lower back), multiple fractures of the ribs, right side (more than one right side of chest had been broken or cracked) and"psychoactive substance abuse (the harmful or excessive use of any chemical substance-such as drugs or alcohol-that alters brain function).^ ^ During a review of Resident 1's History and Physical (H&P)"dated"5/21/2026, the H&P indicated that Resident 1 had the capacity to understand and make decisions.^ During a review of Resident 1's Care Plan for Impaired Physical Mobility, dated 5/21/2026, the Care Plan indicated interventions to assist with transfers and activities of daily living (ADLs). During a review of Resident 1's Care Plan for Risk for Falls related to impaired mobility, pain, and medication effects, dated 5/21/2026, the Care Plan indicated interventions to assist with all transfers. During a review of Resident 1's Care Plan for Acute Pain related to Multiple Traumatic Fractures, dated 5/21/2026, the Care Plan indicated interventions to administer analgesics (pain medication) as ordered and to monitor for opioid (pain medication) side effects such as sedation, constipation, and respiratory depression. During a review of Resident 1's Care Plan for Resident is dependent on staff for meeting emotional, intellectual, physical and social needs related to physical limitations, dated 5/21/26, the Care Plan indicated interventions to ensure that adaptive equipment that the resident needs is provided and is present and functional. During a review of Resident (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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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	health services or any medical follow-up after leaving the facility. Resident 1 stated that he had not been receiving home health services, nursing follow-up, or any other medical monitoring after the facility discharged Resident 1 on 7/28/2026. During an interview on 7/29/2026 at 11:38 AM with the ADON, ADON stated Resident 1 left the facility on 7/27/2026 for a family emergency and failed to return within the authorized timeframe. ADON stated that after multiple unsuccessful attempts to contact Resident 1, the attending physician was notified and issued an order to discharge Resident 1 AMA. ADON stated Resident 1 had not been notified of the AMA discharge prior to returning to the facility on 7/28/2026. ADON stated when Resident 1 returned to the facility at 2 PM on 7/28/2026, it was only then that Resident 1 was informed he had been discharged AMA for not returning to the facility within 4 hours. ADON stated an IDT meeting was conducted, during which Resident 1 was advised to go to the hospital for medical evaluation before the facility would consider readmission. ADON stated that Resident 1 declined to go to the general acute care hospital (GACH) for evaluation, refused to sign the AMA form, and departed the facility at approximately 4 PM after the facility arranged transportation to a friend's residence. ADON stated that no nursing or physical assessment was performed, no vital signs were obtained, no discharge instructions or discharge documentation were provided, and no medications were issued because Resident 1 was discharged AMA. ADON stated that the facility did not provide Resident 1 with a proposed notice of discharge or any other discharge-related documentation prior to informing Resident 1 that he was discharged AMA from the facility. ADON stated that no discharge notice was issued because the facility had designated Resident 1's discharge as AMA. ADON stated Resident 1 was alert and oriented, and left the facility with his personal belongings, wheelchair, and walker. DON stated upon Resident 1's return to the facility on 7/28/2026, a nursing and comprehensive physical assessment should have been conducted before the discharge decision was finalized to evaluate Resident 1 after an extensive leave away from the facility. ADON stated the assessment would have evaluated Resident 1's overall condition after being away from the facility beyond the authorized out-on-pass timeframe and could identify any changes in Resident 1's medical status. During an interview on 7/29/2026 at 12:45 PM with FM 1, FM 1 stated Resident 1 had provided an alternate contact number for a friend and that the facility also had FM 1's telephone number as an emergency contact. FM 1 stated the facility had not contacted FM 1 regarding Resident 1 or informing FM 1 about Resident 1 being discharged AMA from the facility. FM 1 stated Resident 1 was upset that he was discharged AMA without prior notification. During an interview on 7/29/2026 at 1:20 PM with Licensed Vocation Nurse (LVN 1), LVN 1 stated that she had reported to work at 6:45 AM on 7/28/2026 and received shift report that Resident 1 had not returned from his OOP after leaving the facility on 7/27/26 at approximately 10:30 PM. LVN 1 stated she was informed that Resident 1's cellular phone only functioned with Wi-Fi and that he had provided an alternate contact number for his friend. LVN 1 stated Resident 1's FM 1's telephone number was listed as the primary emergency contact. LVN 1 stated she attempted to contact Resident 1 by telephone and left two voicemail messages, and she also called Resident 1's friend's telephone number multiple times but was unable to leave a voicemail. LVN 1 stated Resident 1 returned to the facility at approximately 2 PM on 7/28/2026. LVN 1 stated no nursing or physical assessment was conducted on Resident 1 because she believed the ADON would complete the assessment. LVN 1 stated she understood that Resident 1's AMA discharge had already been initiated upon his return to the facility on 7/28/2026. LVN 1 stated that a comprehensive nursing assessment would have identified any changes in his medical status or immediate healthcare needs prior to his AMA discharge. During a concurrent interview and record review on 7/29/2026 at 1:36 PM with LVN 1, Resident 1's Out-on-Pass Log dated 6/2026 to 7/2026 was reviewed. LVN 1 stated (continued on next page)		

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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	that Resident 1 had not signed out of the facility on 7/27/2026 prior to leaving on an emergency OOP. LVN 1 stated that the log further indicated that Resident 1 had not signed back into the facility upon his return on 7/28/2026. LVN 1 stated it was the responsibility of the charge nurse to have Resident 1 sign out on 7/27/2026 and sign back in on 7/28/2026. During an interview on 7/29/2026 at 2:21PM with the Director of Nursing (DON), DON stated that upon Resident 1's return to the facility on 7/28/2026 a 2 PM, Resident 1 was informed that he had violated the facility's OOP policy, an IDT meeting was conducted, and the AMA discharge for Resident 1 was finalized. DON stated Resident 1 departed alert and oriented with his personal belongings, wheelchair, and walker, and no medications or discharge paperwork were provided because he was discharged AMA. DON stated Resident 1 had previously used his OOP privileges without exceeding the authorized four-hour limit and that this was his first OOP violation. DON stated the facility did not follow the AMA discharge policy by failing to identify, address, or attempt to resolve the circumstances that led to the extended absence before proceeding with the discharge. DON stated he acknowledged that Resident 1 should have received a nursing and physical assessment upon his return to the facility after being out for 16 hours, and that efforts should have been made to resolve the situation prior to finalizing the AMA discharge. During a review of the facility P&P titled "Signing Residents Out revised 8/2006, indicated that each resident leaving the premises (excluding transfers/discharges) must be signed out. The P&P indicated that residents leaving the facility on a physician-approved pass must return within the timeframe specified by the physician and failure to return as ordered may be considered noncompliance with physician orders and the residents plan of care. The P&P indicated that if a resident does not return within the approved timeframe and remain absent for more than four (4) hours beyond the physician-authorized return time, the resident may be subject to voluntary discharge or discharge against medical advice (AMA) by the attending physician, as appropriate. The P&P indicated that residents must be signed in upon return to the facility. During a review of the facility P&P titled "Discharging a Resident Against Medical Advice revised 9/2025, indicated that prior to discharge, the following information is clearly documented in the resident's medical record: The reason, in the resident's (or representative's) words, for requesting the discontinuation of care and/or discharge; Facility staff, provider, and physician attempts to address or correct factors that have led to the request for discharge (e.g., dissatisfaction with care, financial concerns, dependent care, etc.); All information provided to the resident or representative regarding the clinical risks of discontinuing care at the facility, and why it is in the best interest of the resident to stay at the facility and complete the plan of care. The P&P indicated that the physician or provider's assessment of the resident's decision-making capacity; the resident or representative's informed consent for discharge; and any information provided by the resident or representative regarding the setting and care-giving arrangements made for the resident after discharge. The P&P indicated that if a resident or representative requests to be discharged to a setting that does not appear to meet the resident's post-discharge needs, or appears unsafe, the staff and physician will discuss with the resident and/or representative (and document) the implications and/or risks of being discharged to a location not equipped to meet the resident's needs and attempt to ascertain why the resident or representative is choosing that location; discuss with the resident and/or representative (and document) other, more suitable locations equipped to meet the needs of the resident; document if, despite being offered other options that could meet the resident's needs, the resident and/or representative refused the more appropriate settings; and determine if a referral to Adult Protective Services or other state entity charged with investigating abuse and neglect is necessary. The referral should be made at the time of discharge and documented."		