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	04/09/2026

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 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Dispose of garbage and refuse properly. Based on observation, interview, and record review, the facility failed to dispose garbage and refuse properly when: a. One (1) of four (4) dumpsters (a movable waste container designed to be brought and taken away by special collection vehicle, or to a bin that a specially designed garbage truck lifts) was not completely closed and was overflowing with trash when not actively in use. b. The garbage container by the preparation area was not completely covered when not actively being used in the kitchen. These failures had potential to attract birds, flies, insects, pests and potentially spread infection to 124 of 124 facility residents. Findings: a. During a concurrent observation and interview on 4/7/2026 at 9:22 AM, of the dumpster area with the Dietary Supervisor (DS), observed 1 of 4 dumpsters was overflowing with trash. The DS stated 1 dumpster was not completely closed with overflowing trash when not actively use. The DS stated 3 of the dumpsters were not full and staff could have thrown the trash there instead to prevent overflowing. The DS stated the dumpster must be closed completely when not in use to prevent flies in the facility for infection prevention. During an interview on 4/7/2026 at 3:19 PM with the Maintenance Supervisor (MS), the MS stated the dumpster should not be overflowing with trash and should always be close to prevent flies, pests (animals that cause damage and spread disease such as cockroaches, rats and mice) that could lay eggs. The MS stated flies carry diseases that could contaminate food resulting in residents getting sick as a potential outcome. During a review of the facility's Policies and Procedures (P&P) titled, Food-Related Garbage and Refuse Disposal, dated 10/2017, the P&P indicated, 7. Outside dumpsters provided by garbage pickup services will be kept closed and free of surrounding litter. During a review of Food Code 2022, dated 1/18/2023, the Food Code 2022 indicated, 5-501.116 Cleaning Receptacles. Proper storage and disposal of garbage and refused are necessary to minimize the development of odors, prevent such waste from becoming an attractant and harborage of breeding places for insects and rodents, and prevent the soiling of food preparation and food service areas. Improperly handled garbage creates nuisance conditions, makes housekeeping difficult, and may be possible source of contamination of food, equipment, and utensils. Outside receptacles must be constructed with tight-fitting lids or covers to prevent the scattering of the garbage or refuse by birds, the breeding of flies, or the entry of rodents. Proper equipment and supplies must be made available to accomplish thorough and proper cleaning of garbage storage areas and receptacles so that unsanitary conditions can be eliminated. b. During an observation on 4/7/2026 at 9:36 AM, a trash can in the food preparation area was not completely closed when it was not actively being used. During an interview on 4/7/2026 at 9:38 AM, with the DS, the DS stated the lid of the trash can by the preparation area was not closed and the dietary staff were not using it. The DS stated it was important to keep the lid of the trash close to prevent bugs and flies. The DS stated pest droppings could contaminate food, and flies bring diseases that is why it is important to prevent flies going to the kitchen. During a review of the facility's P&P titled Food-Related Garbage and Refuse Disposal, dated 10/2017, the P&P indicated, 2. All garbage and refuse container are provided with tight-fitting lids or covers and must be kept covered when stored or not in continuous use. During a review of Food Code 2022, dated 1/18/2023, the Food Code 2022 indicated, 5-501.113 Covering Receptacles and waste handling units for refuse, recyclables, and returnable shall be kept covered: (A) Inside food establishment if the (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 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	receptacles and units: (1) Contain food residue and are not in continuous use; or (2) After they are filled; and 174 (B) With tight-fitting lids or doors if kept outside the food establishment.

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to complete the Advance Directive Acknowledgment Form (a legal document in which a person specifies what actions should be taken for their health if they are no longer able to make decisions for themselves because of illness or incapacity) with signature to indicate whether an advance directive has been executed, for three of three sampled residents (Resident 7, 9, and 87). This failure had the potential to result in a lack of clarity regarding the residents' healthcare wishes and may impact on the facility's ability to honor those wishes. Findings: 1. During a review of Resident 7's admission Record, the record indicated Resident 7 was admitted to the facility on [DATE] with diagnosis that included metabolic encephalopathy (a condition that can affect cognition, attention, and mental status) and type 2 diabetes mellitus (a chronic condition that requires ongoing monitoring of blood sugar and routine medical). During a review of Resident 7's Minimum Data Set (MDS- a resident assessment and care planning tool), dated 3/23/2026, indicated the resident's functional and cognitive (thought process) was intact. During a review of Residents 7's Advance Directive Acknowledgement Form, dated 12/23/2025, the field was blank and did not indicate whether the resident had or had not executed an Advance Directive. 2. During a review of Resident 9's admission Record, the record indicated Resident 9 was admitted to the facility on [DATE] with diagnosis that included metabolic encephalopathy (a condition that can affect cognition, attention, and mental status). During a review of Resident 9's Minimum Data Set (MDS), dated [DATE], indicated the resident's functional and cognitive (thought process) was intact. During a review of Residents 9's Advance Directive Acknowledgement Form, dated 1/22/2026, the field was blank and did not indicate whether the resident had or had not executed an Advance Directive. 3. During a review of Resident 87's admission Record, the record indicated Resident 87 was admitted to the facility on [DATE] with diagnosis that included metabolic encephalopathy. During a review of Resident 87's Minimum Data Set (MDS), dated [DATE], the MDS indicated Resident 87 was moderately cognitively impaired. During a review of Residents 87's Advance Directive Acknowledgement Form, dated 12/18/2025, the field was blank and did not indicate whether the resident had or had not executed an Advance Directive. During an interview on 4/8/26 at 9:40 a.m. with Social Services Designee (SSD) 1, SSD 1 stated the Advance Directive Acknowledgment Forms for Resident 7,9 and 87 were incomplete. During an interview on 4/9/26 at 2:25 p.m. with SSD 1, SSD 1 stated if the residents do not have an Advance Directive, their care may not be aligned with their wishes and there is a risk of providing unwanted care. During a review of the facility's policy and procedure (P&P) titled, Advance Directives, dated 3/10/2023, the P&P indicated, The facility shall ask residents whether they have executed any Advance Directives.

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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 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interview and record review, the facility failed to provide sufficient nursing staff to meet the resident needs for five (5) of five (5) sampled residents (Resident 10, 43, 44, 46, 104) in accordance with the facility's policy and procedure titled Staffing, Sufficient and Competent Nursing. On 4/4/2026, during 11PM-7AM shift, only two (2) out of seven (7) scheduled Certified Nursing Assistants (CNAs) reported to work and were responsible for providing care for all of the residents in the facility while five (5) other CNAs were no call/no show (when an employee misses a scheduled work shift without notifying their employer). This deficient practice resulted in the residents' dissatisfaction and getting upset due to delays in assistance with activities of daily living (ADLs). All five residents reported waiting for at least one (1) hour and fifteen (15) minutes up to two (2) hours for care. This deficient practice had a potential to increase the risk of skin break down (damage to the skin due to prolong pressure or excessive moisture), skin irritation and the development of skin rashes on Resident 46 and Resident 104 when they had to wait at least 1.5 hours in soiled brief before receiving care. Findings: 1. During a review of Resident 10's admission Record (AR), the AR indicated the resident was readmitted to the facility on [DATE] with a diagnosis that included type 2 diabetes mellitus (DM, a condition when the body does not use sugar properly, causing high blood sugar levels), chronic obstructive pulmonary disease (COPD, long term lung condition that makes it hard to breathe) and endocarditis (infection of the inner lining of the heart). During a review of Resident 10's Minimum Data Set (MDS - a federally mandated resident assessment tool), datedˆ3/5/2026, Resident 10's cognition (thinking) was intact and required moderate assistance (helper does less than half the effort) with ADL's such as oral hygiene, toileting hygiene, shower/bathe and dressing. 2. During a review of Resident 43's AR, the AR indicated the resident was readmitted to the facility on [DATE] with a diagnosis that included cirrhosis of the liver (permanent damage to the liver) and insomnia (inability to fall or stay asleep). During a review of Resident 43's History and Physical (H&P) signed andˆdatedˆ7/16/2025, indicated that Resident 43 had the capacity (a person's ability to think or make decisions changes over time) to understand and make decisions. During a review of Resident 43's MDS, dated [DATE], Resident 43's cognition was intact and required supervision with ADLs care. 3. During a review of Resident 44's AR, the AR indicated the resident was readmitted to the facility on [DATE] with diagnosis that included COPD and type 2 DM. During a review of Resident 44's H&P, signed andˆdatedˆ6/13/2025, indicated that Resident 44 had the capacity to understand and make decisions. During a review of Resident 44's MDS, dated [DATE], Resident 44's cognition was intact and required substantial/maximal assistance with ADLs care. 4. During a review of Resident 46's AR, the AR indicated the resident was readmitted to the facility on [DATE] with diagnosis that included hemiplegia (paralysis [loss of the ability to move] that affects one side of the body), hemiparesis (weakness that affects one side of the body) affecting the right dominant side and type 2 DM. During a review of Resident 46's H&P, signed andˆdatedˆ8/25/2025, indicated that Resident 46 had the capacity to understand and make decisions. During a review of Resident 46's MDS, dated [DATE], Resident 46's cognition was intact and required substantial/maximal assistance with ADLs care. 5. During a review of Resident 106's AR, the AR indicated the resident was readmitted to the facility on [DATE] with diagnosis that included hemiplegia & hemiparesis affecting the left dominant side and hypertension (high blood pressure). During a review of Resident 106's H&P, signed andˆdatedˆ9/2/2025, indicated that Resident 106 had fluctuating capacity to understand and make decisions. During a review of Resident 106's MDS, dated [DATE], Resident 106's cognition was moderately impaired and required substantial/maximal assistance with ADLs care. During a review of the Facility Census, dated 4/4/2026, indicated that the facility census was 127. During a review of the Nursing Staffing Assignment and Sign-In Sheet for 11PM-7AM shift, dated 4/4/2026, indicated (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	that two (2) CNAs (CNA 2, CNA 7) signed in and five (5) CNAs did not sign in. During an interview on 4/6/2026 at 11:08 AM with Resident 10, Resident 10 stated on Saturday 4/4/2026, there were only two CNAs working, which contributed to delays in care. During an interview on 4/7/2026 at 10:20 AM with CNA 3, CNA 3 stated that on 4/4/2026 the Director of Staff Development (DSD) had only scheduled two CNAs to work 11PM-7AM shift. CNA 3 further stated that she witnessed a resident who wandered throughout the facility and required frequent observation during her shift. CNA 3 reported that she had previously informed the DSD that she was unavailable to work Saturdays; however, her name remained on the schedule. During an interview on 4/7/2026 at 10:45 AM with CNA 2, CNA 2 stated that she worked 11PM-7AM shift on 4/4/2026. CNA 2 reported that seven (7) CNAs were originally scheduled; however, five (5) CNAs did not report to work. CNA 2 stated that the facility did not attempt to call in or obtain additional staff to cover the shortage. CNA 2 further stated that she notified the DSD on 4/5/2026 regarding concerns about the staffing on 4/4/2026. During an interview on 4/7/2026 at 11:00 AM with Resident 43, Resident 43 stated that on 4/4/2026 during 11PM-7AM shift, there were only two (2) CNAs available to care for all residents in the facility. Resident 43 reported waiting approximately one (1) hour and fifteen (15) minutes for assistance with ADLs care and expressed being upset due to the delay in care. During an interview on 4/7/2026 at 2:30 PM with Resident 44, Resident 44 stated that on 4/4/2026 during 11PM-7AM shift, there were only two (2) CNAs available to care for all residents. Resident 44 reported waiting approximately two (2) hours for assistance with ADLs care and expressed dissatisfaction with the delay in care. During an interview on 4/7/2026 at 2:39 PM with Resident 46, Resident 46 stated that on 4/4/2026 during 11PM-7AM shift, Resident 46 observed only two (2) CNAs assisting all residents. Resident 46 reported waiting approximately one and a half (1.5) hours in a soiled brief before receiving assistance. During an interview on 4/7/2026 at 2:45 PM with Resident 104, Resident 104 stated that on 4/4/2026 during 11PM-7AM shift, there were only two (2) CNAs providing care for all residents. Resident 104 reported that a CNA informed him that care would be delayed due to short staffing. Resident 104 stated that he waited approximately two (2) hours to be changed and reported that his brief was saturated with urine at the time of care. Resident 104 expressed being very upset due to the delay in care. During an interview on 4/8/2026 at 11:36 AM with the DSD, the DSD stated that on 4/4/2026, seven (7) CNAs were scheduled for the 11PM-7AM shift; however, five (5) CNAs were no call/no show. The DSD stated she was not notified in advance that the CNAs would not report to work. The DSD stated that the Assistant Director of Nursing (ADON) contacted her at approximately 12:02 AM on 4/5/2026; however, the DSD did not respond until 6:56 AM when she awoke and subsequently went to the facility to assess the situation. The DSD stated that there was a binder at the nursing station containing CNA names and contact information; however, she was unsure if the 11PM-7AM shift Registered Nurse (RN) had attempted to contact the absent CNAs. The DSD stated if she had been notified timely, she would have reported to the facility to assist. The DSD acknowledged that the facility did not have sufficient CNA staff on 4/4/2026 for 11PM-7AM shift to meet resident care needs, which resulted in delayed ADLs care, inadequate supervision for wander residents, and increased potential for resident harm, including injury. During an interview 04/08/2026 at 12:00 PM with the ADON, the ADON stated that on 4/4/2026 at approximately 11:40 PM, the RN supervisor notified her that five (5) CNAs had not reported to work, leaving only two CNAs to provide care for all of the facility residents. The ADON stated she sent a text message to the DSD at approximately 12:00 AM to notify her of the staffing shortage. The ADON further stated that attempts were made to contact the absent CNAs; however, they did not respond. The ADON acknowledged that due to insufficient staffing, resident care including assistance with ADLs was delayed. The ADON further stated that inadequate staffing increased the risk for adverse outcomes, including falls, injuries, and skin breakdown. During a review of the facility's Policy and Procedures (P&P) titled, Staffing, Sufficient and Competent Nursing, dated 2021, indicated that the facility provides sufficient numbers of nursing staff with the appropriate skills and competency necessary to provide nursing and related (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	care and services for all residents in accordance with resident care plans and the facility assessment. The P&P indicated that licensed nurses and certified nursing assistants are available 24 hours a day, seven (7) days a week to provide competent resident care services including: assuring resident safety; attaining or maintaining the highest practicable physical, mental, and psychosocial well-being of each resident. During a review of the facility's P&P titled, Safety and Supervision of Residents, revised 4/2017, indicated that resident safety and supervision and assistance to prevent accidents are facility-wide priorities. The P&P indicated that resident supervision is a core component of the systems approach to safety.

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. Based on observation, interview, and record review, the facility failed to prepare food in a form designed to meet individual needs when pureed (a smooth, thick liquid or paste made by mashing, blending, or straining cooked food) cream of rice was flat on the plate and did not hold its shape. These failures had the potential to result in difficulty in swallowing, decrease in food and nutrient intake to 15 of 15 residents on puree diet (food that are soft and pudding like consistency), resulting in unintended (not planned) weight loss and choking (when food gets stuck in your airway, blocking the flow of air to your lungs). Findings: During a review of the facility's cook spreadsheet (a sheet containing the kind and amount of food each diet would receive) titled, Winter 2026, dated 4/6/2026, the spreadsheet indicated residents on puree diet/International Dysphagia Initiative ([IDDSI] a framework for categorizing food textures and drink thickness) Level 4 (foods that are soft and pudding like consistency) would include the following foods on the tray: Pureed pork chop 1/2 cup (c, household measurement) Herbed cream of rice 4 ounces (oz, a unit of measurement) Puree mixed vegetables 1/2 c Puree bread with margarine 1 each Puree peach cobbler 1/2 c During an observation on 4/6/2026 at 12:32 PM, of the tray line (an area where foods were assembled form the steamtable [kitchen appliance that keeps food warm at a safe temperature for serving] to resident's plates) with the Registered Dietitian 2 (RD 2), an herbed cream of rice served on puree diet was flat on the plate. In a concurrent interview, RD 2 stated they were going to fix and replace it as the cream of rice was flat on the plate. During an observation on 4/6/2026 at 12:46 PM, RD 2 was preparing the puree herbed cream of rice, observed RD 2 added slurry and mixing it with a whisk. During an observation on 4/6/2026 at 12:54 PM, of the herbed cream of rice, served on the plate was flat and touching other food items. During an interview on 4/6/2026 at 1PM with Registered Dietitian 1 (RD 1), RD 1 stated they made puree bread as a substitute for herbed cream of rice as it was too watery, and puree bread was safer to serve. During an interview on 4/7/2026 at 10:07 AM, with the Dietary Supervisor (DS), the DS stated the puree cream of rice yesterday had too much water. The DS stated [NAME] 1 did not follow the recipe for preparing puree food yesterday. The DS stated puree food was supposed to be thick and not sticky but yesterday, and the herbed cream of rice was too sticky, it was spreading out on the plate and did not hold its shape on the plate. The DS stated residents could choke, would not get their nutritional needs as they would not eat it resulting in weight loss as a potential outcome of puree food not in their right consistency. During an interview on 4/7/2026 at 3:08 PM with RD 1, RD 1 stated the puree herbed rice did not hold its shape on the plate yesterday. RD 1 stated when he spoke to [NAME] 1 and [NAME] 1 put the cream of rice in the blender instead of mixing it. RD 1 stated [NAME] 1 did not follow instruction indicated in the recipe. RD 1 stated residents with dysphagia (difficulty swallowing) could have choking hazards, aspiration (accidental breathing in of food and liquid into the airway and lungs) causing threat to resident's health as potential outcomes of inappropriate food textures. During a review of the facility's policies and procedures (P&P) titled Diet Manual (Dietary Services), undated, the P&P indicated, the facility shall maintain and utilize a current, standardized diet manual approved by a Registered Dietitian (RD) to guide therapeutic diets, ensuring nutritional adequacy, safety, and compliance. Purpose: to provide a reference for therapeutic diets, texture modifications, and nutritional standards that support resident health, physician orders, and interdisciplinary care planning. During a review of the facility's diet manual (a manual containing different diets descriptions, foods allowed and avoided and sample menus the facility have) titled IDDSI Level 4: Regular Pureed Diet, undated, the diet manual indicated, The facility shall provide IDDSI Level 4 (Pureed) diets that meets standardized texture requirements to ensure safe swallowing, adequate nutrition, and resident dignity.Definition: IDDSI level 4 foods are extremely thick, smooth and lump free, does not require chewing, hold shape on a spoon and fall off easily when titled. The Diet Manual further indicated, IDDSI level 4 food must be moist and cohesive and avoid (continued on next page)

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	over thinning (must not be liquid). During a review of the facility's P&P titled, Standardized Recipe, undated, the P&P indicated, The facility shall utilize standardized recipes for all menu items to ensure consistency, nutritional adequacy, food safety, and quality. Dietary staff must follow recipes exactly as written. Recipes must be used for all meals, including therapeutic diets. During a review of the facility's standardized recipe titled Herbed Cream of Rice, dated 2026, the recipe indicated, Method: Measure water into heavy stockpot. Bring to boil. Stir the dry cereal into boiling salted water.Cook for 1 minute.Cover and remove from heat. Stir in the margarine, spices and seasonings. Let stand for 2-3 minutes.Serve with a 4 oz ladle per portion. CCP: All IDDSI texture modifications need to pass their established testing methods that at the tart and every 15 minutes for duration of service. During a review of the IDDSI guideline website titled IDDSI, dated 7/2019, the IDSSI guideline indicated, Level 4 Pureed is usually eaten with spoon, falls off spoon in a single spoonful when tilted and continues to hold shape on the plate, no lumps, not sticky, and liquid must not separate from solid. Can be piped, layered or molded because it retains its shape but should not require chewing if presented in this form. Food testing method: Spoon tilt test and fork drip test.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record review, the facility failed to ensure safe and sanitary food storage and food preparation practices in the kitchen when: Kitchen equipment and utensils were not free from dirt, dust and food debris. Reach-in freezer bottom shelves by the walk-in refrigerator had dirt and cardboard boxes debris. Reach-in freezer bottom shelves by the ice machine had dirt, dust and cardboard boxes debris. Dry storage floor had dirt and trash accumulation in the corner. Kitchen utensils drawer and pots and pans storage area had food debris. Pots and pans storage area had dirt and food debris. 2. Reach-in freezer temperature was at 15 degrees Fahrenheit (F, a scale of temperature) on 4/6/2026, and 7 F on 4/7/2026 and blank on 4/3/2026 in the afternoon shift. Two trays of sandwiches were not labeled and dated. Two dented (a hallow, dip, or depression on a surface, caused by blow, impact or pressure) cans were stored with non-dented cans. Dietary Aide 2 (DA 2) did not cover his beard completely while preparing puree dessert. Staff did not perform hand hygiene properly when: Dietary Aide 1 (DA 1) touched the towel dispenser knob after washing his hands then proceeded to prepare desserts. [NAME] 1 touched the towel dispenser knob after washing his hand and touched the scoops. [NAME] 1 touched the lid of the trash then proceeded to prepare food. Dietary Aide 3 (DA 3) did not wash his hands or did not change his gloves when touching soiled dishes and putting away clean and washed dishes. Soiled towel was on top of the preparation area while [NAME] was cooking. Coffee scoop was not washed after every use.Blue bin was cracked, with coffee residue and debris touching the lips of disposable cups used for resident's coffee. Sixty (60) of 65 resident's trays were cracked and chipped.Cook 1 was chewing gum during lunch trayline (an area where foods were assembled from the steamtable [kitchen appliance that keeps food warm at a safe temperature for serving] to resident's plates). DA 1 was wearing a nose ring. Pans were stacked wet in the pan storage area. Residents' refrigerator in the activity room had dirt accumulation. The attached freezer had no thermometer and had ice buildup. These failures had the potential to result in harmful bacterial growth and cross contamination (transfer of harmful bacteria from one place to another) that could lead to foodborne illness (a disease caused by consuming food or drinks that are contaminated by germs or chemicals) in 124 of 127 medically compromised residents who received food and ice from the kitchen. Findings: 1a. During concurrent observation and interview on 4/6/2026 at 8:54 AM, of the reach-in freezer near the walk-in refrigerator with the Dietary Supervisor (DS), the reach-in freezer bottom shelves had dirt debris. The DS stated there was ice and dirt debris at the bottom of the shelves, and it is not okay because of cross-contamination. The DS stated the reach-in freezer cleaning had to be done daily so that germs would not be transferred to food and residents would not get sick from foodborne illness. b. During a concurrent observation and interview on 4/6/2026 at 9:17 AM in the kitchen with the DS, dirt debris was on the bottom of the reach-in freezer. The DS stated the reach-in freezer should be cleaned every day and he did not think the staff cleaned it last night (4/5/2026) because there was dirt debris. The DS stated it was important to maintain the reach-in freezer cleanliness to prevent cross-contamination. During a review of the facility's policies and procedures (P&P) titled Policy: Refrigerator and Freezer Sanitation and Cleanliness (Dietary Services), undated, the P&P indicated, The facility shall maintain all dietary refrigerators and freezers in a clean, sanitary, and proper functioning condition to ensure safe food storage and prevent contamination, in compliance with the CMS food safety standards and California Title 22 regulations. To prevent foodborne illness, ensure food safety, and maintain compliance with infection control and dietary service regulations. Refrigerators and freezers cleaning include: shelves, walls, gaskets, handles, and door surfaces, removal of debris, spills and expired items. c. During an observation on 4/6/2026 at 9:33 AM in the dry storage area, a pile of trash and dirt was on the floor in the corner back. During an interview on 4/6/2026 at 9:38 AM with the DS, the DS stated they deep clean the dry storage room every (continued on next page)

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	055899	A. Building B. Wing	04/09/2026

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Wednesday to prevent rodents (small, furry animals such as mice and rats). The DS stated the dirt and trash accumulation on the floor was not okay as it could attract pest (animals that cause damage and spread disease such as cockroaches, rats and mice) and pest dropping could get into the containers and get to the food causing cross-contamination. During a review of the facility's P&P titled Policy: Dry Food Storage (Dietary Services), undated, the P&P indicated, Dry storage areas are cleaned weekly and as needed. Cleaning includes: shelves, floors, corners, and containers, removal of spills, crumbs and debris. During a review of Food Code 2022, dated 1/18/2023, the Food Code 2022 indicated,4-602.13 Nonfood-Contact Surfaces. Nonfood-contact surfaces of equipment shall be cleaned at a frequency necessary to preclude accumulation of soil residues. d. During an observation on 4/7/2026 at 9:39 AM of the kitchen utensils drawer, food debris was in the drawer. During an interview on 4/7/2026 at 9:42 AM with the DS, the DS stated the kitchen utensils drawer was dirty and it had food debris. The DS stated the kitchen staff needed to clean the drawer daily and after each service. During a review of the facility's P&P titled Dietary Services Policy, undated, the P&P indicated, To ensure the dietary services kitchen is maintained in a clean, sanitary, and safe condition at all times in order to prevent food contamination, maintain food quality, and comply with health and safety standards. All equipment, utensils, and food contact surfaces shall be cleaned and sanitized before and after use. e. During a concurrent observation and interview on 4/7/2026 at 9:42 AM with the DS in the kitchen, food debris was in the pot and pans storage area. The DS stated the pots and pans area were not cleaned last night (4/6/2026) because it had food debris and it was not okay because of cross-contamination. During a review of the facility's P&P titled Dietary Services-Kitchen Overall Cleanliness, undated, the P&P indicated, All food preparation, service, and storage areas shall be maintained in a sanitary condition. During a review of Food Code 2022, the Food Code 2022 indicated, 4-601.11 (E) Except when dry cleaning methods are used as specified under S 4-603.11, surfaces of utensils and equipment contacting food that is not time/temperature control for safety food shall be cleaned: (1) At any time when contamination may have occurred; (2) At least every 24 hours for iced tea dispensers and consumer self-service utensils such as tongs, scoops, or ladles; (3) Before restocking consumer self-service equipment and utensils such as condiment dispensers and display containers; and (4) In equipment such as ice bins and beverage dispensing nozzles and enclosed components of equipment such as ice makers, cooking oil storage tanks and distribution lines, beverage and syrup dispensing lines or tubes, coffee bean grinders, and water vending equipment: (a) At a frequency specified by the manufacturer, or (b) Absent manufacturer specification, at a frequency necessary to preclude accumulation of soil or mold. 2. During an observation on 4/6/2026 at 8:48 AM in the kitchen, no temperature was recorded in the facility's Reach-in Freezer Log for 4/3/2026. During an observation on 4/6/2026 at 9:02 AM, the inside thermometer of the reach-in freezer was at 15 F while the temperature recorded on the log dated 4/5/2026 was 7 F. There was no corrective action indicated on the log. During an interview on 4/6/2026 at 9:07 AM, with the DS, the DS stated they check the freezer temperature three (3) times a day and the freezer should be maintained at 0 F to -10 F to prevent food from defrosting in the freezer. The DS stated the food needed to stay frozen in the freezer to prevent residents from getting sick with foodborne illness. The DS stated if the freezer temperatures were outside the temperature ranges of 0 F to -10 F, the dietary staff should take the food out from freezer and throw it away. During a concurrent interview and record review on 4/6/2026 at 9:10 AM with the DS, the facility log titled, Reach-in Freezer Log, dated April 2026, was reviewed. The log indicated 7 F on 4/5/2026 at 6:55 AM and there was no recorded temperature on 4/3/2026 for the evening shift. The log did not indicate any corrective action. The DS stated the temperature on 4/5/2026 is -7 F and the staff forgot to put a negative sign. The DS stated there was no temperature recorded on 4/3/2026 and it's the responsibility of the PM cook. The DS further stated it is important to monitor temperature to ensure food is staying frozen in the freezer for food safety. During a review of the facility's P&P titled, Policy: Temperature Maintenance-Refrigerators and Freezers (Dietary Services), undated, the P&P (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	indicated, The facility shall ensure that all refrigerators and freezers used for food storage are maintained at safe temperatures, monitored routinely, and documented.Freezers must be maintained at 0 F or below. Logs include date and time, temperature reading, staff initials and signature. Logs are reviewed by supervisor/designee routinely. If temperature is outside the acceptable range: Recheck temperature immediately Adjust thermostat or ensure door is properly closed Notify dietary supervisor/maintenance Assess food for safety and discard if compromised Document corrective action taken. 3. During an observation on 4/6/2026 at 9:19 AM in the walk-in refrigerator, two trays of sandwiches were not labeled and dated. During an interview on 4/6/2026 at 9:25 AM with the DS, the DS stated all food should be labeled and dated upon opening and during delivery. The DS stated the process of labeling and dating included using a date gun indicating received date, prepared date and if it was prepared sandwiches, the whole tray had to be labeled with the sandwich name and three (3) days shelf life (the length of time for which an item remains usable for consumption). The DS stated he prepared the sandwiches last Friday (4/3/2026) and he did not label them. The DS stated he was new and trying to learn the position. The DS stated it was important to label and date the food so they would know when the food item would expire for the staff not to give residents bad food. The DS stated residents could get food poisoning as a potential outcome. During a review of the facility's P&P titled Food Labeling and Dating (Dietary Services), undated, the P&P indicated, All food items stored in the facility shall be properly labeled and dated to ensure safe consumption, prevent contamination, and comply with CMS and California Title 22 regulations. All items must be clearly labeled with: name of food item, date received or prepared, date opened (if applicable), use-by or discard date (if applicable). During a review of Food Code 2022,dated 1/18/2023, the Food Code 2022 indicated, 3-501.17 Commercially processed food, open and hold cold, (B) except specified in (E) - (G) of this section, refrigerated, ready-to-eat time/temperature control for food safety food prepared and packed by a food processing plant shall be clearly marked, at the time the original container is opened in a food establishment and if the food is held for more than 24 hours, to indicate the date or day by which the food shall be consumed on the premises, sold, or discarded, based on the temperature and time combinations specified in (A) of this section and (1) The day the original container is opened in the food establishment shall be counted as Day 1; and (2) The day or date marked by the food establishment may not exceed a manufacture's use-by- date if the manufacturer determined the use-by date based on food safety. 4. During an observation on 4/6/2026 at 9:33 AM in the dry storage room, there was a designated area for dented cans storage. During a concurrent observation and interview on 4/6/2026 at 9:42 AM with the DS in the dry food storage area, two dented cans were stored with non-dented cans. The DS stated there is a designated dented can area with label by the corner for the staff to use. The DS stated the dented cans are picked up by the vendor every Wednesday. The two dented cans should not be stored with non-dented cans because if consumed, residents could get food poisoning from botulism (a rare and serious illness caused by toxin produced by bacteria of improperly canned food) as the air could spoil the food and grow mold. During a review of the facility's P&P titled, Policy: Dented Cans and Damaged Food Containers (Dietary Services), undated, the P&P indicated, The facility shall ensure that all canned and packed food items are inspected upon receipt and prior to use, and that any dented, swollen, leaking, or damaged cans are immediately removed from service.To prevent foodborne illness and contamination by ensuring that compromised food containers are not used or served to residents. Damaged cans must be removed from food storage area and dented cans are segregated in the designated storage area. During a review of Food Code 2022, dated 1/18/2023, the Food Code 2022 indicated, 3-101.11 Safe Unadulterated, and Honestly Presented. Food shall be safe, unadulterated, and, as specified under 3-601.12, honestly presented. 3-201.11 Compliance with Food Law. A primary line of defense ensuring that food meets the requirements of S3-101.11 is to obtain food from approved sources, the implications of which are discussed below. However, it is also critical to monitor food products to ensure that, after harvesting, processing, they do not fail victim to conditions that endanger their (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	safety, make them adulterated, or compromise their honest presentation. The regulatory community, industry, and consumers should exercise vigilance in controlling the conditions to which foods are subjected and be alert to signs of abuse. FDA considers food in hermetically sealed containers that are swelled or leaking to be adulterated and actionable under the Federal Food, Drug, and Cosmetic Act. Depending on the circumstances, rusted, and pitted or dented cans may also present a serious potential hazard. 5. During an observation on 4/6/2026 at 11:05 AM in the food preparation area, DA 2 did not completely cover his beard. During a concurrent observation and interview on 4/6/2026 at 11:14 AM in the food preparation area, DA 2 was preparing fruit and dessert while wearing his beard guard halfway to his chin and did not cover all of his facial hair. The DS stated the policy is for the staff to cover all facial hair with a beard guard so it would not go in the food to prevent cross-contamination. During a review of the facility's P&P titled, Policy: Hair Restraints-Dietary/Kitchen Staff, undated, the P&P indicated, All dietary staff shall wear appropriate hair restraints to prevent contamination of food Purpose: To minimize the risk of hair and other contaminants entering food, ensuring safe food handling and infection control. All staff must wear effective hair restraints, including beard guards for facial hair. During a review of Food Code 2022, dated 1/18/2023, the Food Code 2022 indicated 2-402 Hair Restraints. 2-402.11 Effectiveness (A) except as provided in (B) of this section, FOOD EMPLOYEES shall wear hair restraints such as hats, hair coverings or nets, beard restraints, and clothing that covers body hair, that are designed and worn to effectively keep their hair from contacting exposed food, clean equipment, utensils, and linens, and unwrapped single-service and single use article. 6a. During an observation on 4/6/2026 at 11:06 AM by the sink area, DA 2 washed his hands, touched the towel dispenser knob for some paper towel, wiped his hands, then proceeded to put on gloves and touched clean residents' small plates. During an interview on 4/6/2026 at 11:19 AM with the DS, the DS stated staff should not touch the knob of the towel dispenser after washing their hands because it could contaminate their hands. The DS stated DA 1 should have washed his hands again before going back to work. b. During an observation on 4/6/2026 at 11:31 AM by the sink area, [NAME] 1 washed his hands, touched the paper towel knob dispenser, dried his hands with the paper towel, and proceeded to cook. During an interview on 4/6/2026 at 12:11 PM with the DS, the DS stated [NAME] 1 should wash his hands again after touching the towel dispenser knob before cooking the residents' food to prevent cross-contamination. c. During an observation on 4/6/2026 at 12:07 PM in the kitchen, [NAME] 1 used his hands to lift the cover of the garbage can, then proceeded to touch the tongs and other kitchen utensils without washing his hands. During an interview on 4/6/2026 at 12:11 PM with the DS, the DS stated [NAME] 1 touched the lid of the garbage container so he should have washed hands before proceeding to work to prevent the spread of infection to the residents. d. During an observation on 4/7/2026 at 8:58 AM in the dishwashing area, DA 3 loaded soiled domes in the rack then touched the clean trays. After that, DA 3 went to the two (2)-compartment sink to rinse his gloves, then touched the clean pans and put them away in the storage area. During an interview on 4/7/2026 at 9:03 AM with the DS, the DS stated DA 3 needed to change his gloves when moving from touching the dirty dishes to putting away clean dishes for infection control precaution. The DS stated the dishes that DA 3 washed needed to be rewashed because they were contaminated by his dirty hands. During a review of the facility's P&P titled, Policy: Hand Hygiene-Dietary/Kitchen Services, undated, All dietary staff shall perform proper hand hygiene to prevent contamination and foodborne illness.When to wash hands: starting work handling food or clean equipment donning gloves handling garbage or cleaning chemicals removing gloves contact with contaminated surfaces. The P&P further indicated Proper handwashing techniques included: wet hands with warm water apply soap and lather thoroughly scrub all surfaces for at least 20 seconds rinse thoroughly dry hands with disposable paper towel use towel to turn off faucet. During a review of the facility's P&P titled, Ware Washing, undated, the P&P indicated, 8. If the same person is loading and unloading the racks, hands must be washed and a clean apron worn before unloading the clean dishes. During a review of Food Code (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	stated they monitor the temperature of compliance and if there were any spoiled food. The DS stated there should not be any ice buildup in the freezer and no dirt and dust accumulation on the gasket because it could cause cross-contamination. During an interview on 4/7/2026 at 2:45 PM, with the Administrator (ADM), the ADM stated they do not have a refrigerator for residents outside food and the refrigerator in the activities room is used for resident's related activities. During a review of the facility's P&P titled, Temperature Maintenance-Refrigerators and Freezers (Dietary Services), undated, the P&P indicated, Each unit has a functional thermometer (internal or external). Refrigerators and freezers are clean and in good working condition, not overstocked (allowing proper air circulation). free from excessive frost and ice buildup.

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Royal Palms Post Acute	630 W. Broadway Glendale, CA 91204

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F 0813 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Have a policy regarding use and storage of foods brought to residents by family and other visitors. Based on observation, interview, and record review the facility failed to provide a safe storage (refrigerator) designated for resident's leftovers or food coming from the outside source to 124 of 127 residents. This failure had the potential to result in spoiled food and food borne illness (a disease caused by consuming food and drinks that are contaminated by germs or chemicals) to residents. Findings: During an interview on 4/7/2026 at 10:10 AM, with the Dietary Supervisor (DS), the DS stated they do not store resident's food from home for the residents as they took all the refrigerators out and it was him who maintained it and maintenance staff removed them. During a concurrent observation and interview on 4/7/2026 at 2:29 PM, of the refrigerator in the activities room, a sign posted on the door indicated, Patients food are not allowed in this fridge. The DS stated, this refrigerator might be the refrigerator used for food from the outside source and the policy that the staffs follow is the policy for the residents to consume the food right away and any leftover that the residents did not eat was be tossed out. During an interview on 4/7/2026 at 2:35 PM, with the Administrator (ADM), the ADM stated they do not have any designated storage for residents' food brought to the facility from the outside source. The ADM stated residents needed to eat their food immediately and all the leftovers would be tossed out or they asked the family to come back and take the food back home. During an interview on 4/7/2026 at 2:40 PM with the Director of Nursing (DON), the DON stated that residents are not allowed to bring food from home. He added that he is still unfamiliar with the facility's policies since he recently started in March 2026. The DON also stated that the facility has a designated resident refrigerator, but he does not know its location. During a concurrent interview and record review on 4/7/2026 at 2:45 PM, with the ADM, the facility's undated P&P titled, Food Brought from Outside (Resident Use) and Food from the Outside Source were reviewed. The ADM stated that the facility follows the Food from the Outside Source policy and does not store any outside food for residents; any leftovers are discarded. The ADM explained that bringing in outside food is part of residents' rights and supports a home-like environment, but the facility limits the amount to what residents can consume. The ADM also stated the facility does not have a refrigerator designated for residents' food. During an interview on 4/7/2026 at 2:55 PM with the Assistant Director of Nursing (ADON), the ADON stated many families bring outside food for residents, especially during holidays. The ADON explained that families often bring large quantities of homeˆcooked meals, and staff ask them to take the excess food back home. During an interview on 4/7/2026 at 3:03, PM with the ADM, the ADM stated the facility will revamp (revise) their policy and upgrade the refrigerator so that residents could store their food coming from the outside source safely. During an interview on 4/7/2026 at 3:06 PM with the DS, the DS stated, that having a designated refrigerator for residents outside food was important to prevent food from spoiling. The DS stated food was sometimes left at the bedside which was unsafe. The DS stated failure to store food brought for the residents from outside could result in the resident's feeling to be emotionally upset, or/and weight loss and or the resident to be hungry During an interview on 4/7/2026 at 3:14 PM with the Registered Dietitian 1 (RD 1), RD 1 stated they do not have a refrigerator designated for residents bringing food from the outside and the facility did not have a clear and structured policy about storing food or leftover food of the residents. RD 1 stated they need a refrigerator to store residents' food to prevent foodborne illnesses. During a review of the facility's Policies and Procedures (P&P) titled, Food Brought From Outside (Resident Use), undated, the P&P indicated, The facility allows food to be brought in from outside sources for resident consumption, provided that food safety, infection control, and dietary restrictions are maintained.All outside food stored in facility refrigerators must be: labeled with resident name and date received.Food must be stored separately from facility food supplies. During a review of the facility's P&P titled, Food from Outside Sources, undated, the P&P indicated, Food from outside sources is discouraged due to concerns related to food safety, infection control, and the need to maintain compliance with prescribed therapeutic diets. However, residents have the (continued on next page)

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F 0813 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	right to choose and consume food from outside sources in accordance with their preferences. 4. The facility is not responsible for food safety concerns related to outside food. Staff will provide education regarding food safety and infection control. 5. Only small quantities sufficient for immediate consumption should be brought in. Any leftovers will be discarded. During a review of the facility's P&P titled, Food Brought from Outside the Facility, undated, the P&P indicated, All outside food will be stored promptly (refrigerated if perishable within 2 hours). Food will be stored in designated refrigerator or facility refrigerator in labeled containers.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure Certified Nursing Assistant (CNA) 1 wore an isolation gown when providing high-contact resident care activities (activity of daily living or ADL tasks that require close, prolonged physical interaction between staff and residents, likely to transfer germs to a caregiver's hands or clothing) for one of four sampled residents (Resident 84) who was placed on Enhanced Barrier Precautions (EBP-an infection prevention and control intervention to reduce the spread of multidrug resistant organisms [MDRO- disease causing organism resistant to medication used to treat infection]) due to multiple vascular ulcers (a slow-healing, open sore on the leg or foot caused by poor circulation) on the resident's left foot. On 4/6/2026, CNA 1 was observed providing personal care to Resident 84 and CNA 1 stated she gave a bed bath and changed Resident 84's brief without wearing isolation gown. This deficient practice had the potential to result in Resident 84 acquiring MDROs and/or spreading MDROs to other residents in the facility which could negatively affect their health and quality of life.Findings: During a review of Resident 84's admission Record (AR), indicated Resident 84 was admitted on [DATE], with diagnoses that included right side hemiplegia (a form of paralysis that causes severe or complete loss of movement on one side of the body), muscle wasting, peripheral vascular disease (PVD- narrowing or widening of veins and arteries, impacting blood flow throughout your body), and reduced mobility. During a review of Resident 84's care plan (CP) with the focus on Resident 84's ADL self-care performance deficit related to physical limitations, dated 3/6/2026, the CP indicated the nursing interventions included EBP for staff to utilize gowns and gloves for high-contact resident care activities such as dressing, bathing, providing hygiene, changing linens, changing briefs, and wound care/skin care. During a review of Resident 84's Minimum Data Set (MDS- a resident assessment tool) dated 3/12/2026, indicated Resident 84's cognitive status (ability to process and comprehend information) was intact. The MDS indicated Resident 84 requires substantial/maximal assistance (helper does more than half the effort) with bathing, toileting, personal hygiene and dressing. During a review of Resident 84's Order Summary Report (OSR) dated 3/23/2026, the OSR indicated left lateral malleolus vascular (outside of your ankle) ulcer treatment: cleanse with normal saline (NS-a sterile, salt-and-water solution with a concentration similar to human blood and tears), pad dry, paint with betadine (a brand of antiseptic [germ-killing] medicine used to prevent infections) and cover with dry dressing every day shift for wound management. During a review of Resident 84's OSR dated 3/30/2026, the OSR indicated left midfoot (central region of the foot) vascular ulcer treatment: cleanse with NS, pad dry, paint with betadine and cover with dry dressing every day shift for wound management. During a review of Resident 84's OSR dated 4/5/2026, the OSR indicated left plantar (sole of the foot) vascular ulcer treatment: apply A and D ointment (a thick cream used to soothe, moisturize and protect irritated skin) and cover with dry dressing every day shift for wound management. During a review of Resident 84's OSR dated 4/6/2026, the OSR indicated Resident 84 had a physician order to be placed on EBP that required staff to utilize gowns and gloves for high-contact resident care activities. During a review of Resident 84's CP with the focus on infection prevention, dated 4/6/2026, the CP indicated Resident 84 was at risk for infection, had a potential for transmission of MDRO that related to multiple wounds (left plantar foot vascular ulcer, left midfoot vascular ulcer, and left lateral malleolus vascular ulcer). The CP indicated the interventions included to implement EBP ensuring gowns and gloves are worn for all high contact activities that includes bathing and personal hygiene. During an observation on 4/6/2026 at 11:27 AM in front of Resident 84's room, an EBP signage indicated the use of gloves and gown for high contact care that includes bathing and changing briefs was posted by the resident's door. Inside Resident 84's room, CNA1 was not wearing an isolation gown while providing care for Resident 84. During a concurrent observation and interview on 4/6/2026 at 11:30 AM with CNA 1 in Resident 84's room, Resident 84 has a wound dressing on his left foot. CNA 1 stated, she gave (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident 84 a bed bath and changed his briefs without wearing an isolation gown because she was not aware that she needed to use an isolation gown for his care. During an interview on 4/6/2026 at 11:51 AM with the Infection Preventionist Nurse (IPN), the IPN stated, CNA 1 should have worn a gown during close contact care with Resident 84 such as bed bath and changing briefs, because of Resident 84's multiple vascular ulcers on his left foot to prevent Resident 84 acquire MDRO and prevent spread of MDRO to other residents in the facility. During an interview on 4/7/2026 at 11:43 AM with the Director of Nurses (DON), the DON stated, Resident 84 requires EBP because of his multiple vascular ulcers on his left foot, and staff needs to wear PPE such as isolation gown when providing close contact care such as bathing and changing briefs. The DON stated, not wearing an isolation gown when providing close contact care to Resident 84, had the potential for Resident 84 to acquire MDRO and possibly spread MDRO to other residents in the facility. A review of the facility's policy and procedure (P&P) titled, Enhanced Barrier Precautions, dated 12/2024, the P&P indicated: a) EBP are utilized to prevent the spread of MDROs to residents, b) EBP apply when a resident is not known to be infected or colonized with any MDRO, has a wound and does not have secretions or excretions that are unable to be covered or contained; c) EBPs employ targeted gown and gloves use in addition to standard precautions during high contact resident care activities; gloves and gown are applied prior to performing the high contact resident care activity; and c) High contact resident care activities requiring the use of gowns include bathing and changing briefs.

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to maintain or enhance resident dignity for 2 of 6 sampled residents (Resident 121 and Resident 93) by failing to ensure: 1.A privacy bag/cover was placed over Resident 121's urinary drainage container (a bag/container that stores urine after it leaves the body), which exposed the contents and compromised the resident's dignity. 2. The Certified Nursing Assistant (CNA 4) did not stand while assisting Resident 93 with meals to maintain an eye level during a meal service. These deficient practices have the potential to cause embarrassment, loss of dignity, privacy, and emotional distress for residents and not promoting a dignified dining experience could make residents feel rushed, disrespected, or uncomfortable during care. Finding: 1.During a review of Resident 121's admission record indicated the resident was originally admitted to the facility on [DATE] with a diagnosis that included metabolic encephalopathy (not thinking clearly because something in body is out of balance, such as an infection, or problems with organs), neuromuscular dysfunction of bladder(a person has trouble controlling their bladder because the nerves and muscles are not working properly) , and paraplegia(loss of movement and or feeling in the lower half of the body) . During a review of Resident 121's History and Physical (H&P) dated 3/4/2026, H&P indicated that Resident 121 has the capacity to understand and make decisions. During a review of Resident 121's Minimum Data Set (MDS, a standardized assessment and care screening tool), dated 1/26/2026, indicated Resident 121 was cognitively intact (able to think clearly with no memory impairment and understanding). During a concurrent observation and interview on 04/06/2026 at 09:40AM with Resident 121 was observed with a urinary drainage that was not covered for privacy. Resident 121 was asked how they felt about the catheter bag being uncovered, Resident 121 stated, I would like the bag to be covered. It looks bad. It's embarrassing. During a concurrent observation and interview on 4/6/2026 at 9:45 AM with Licensed Vocational Nurse (LVN) 5 stated, Resident 121's urinary drainage container had no privacy cover. LVN 5 acknowledged the observation and stated that a privacy bag should be in place to maintain resident dignity. Stating she had received education for Resident dignity. During a concurrent observation and interview on 4/6/2026 at 9:52AM with Director of Staff Development (DSD), Resident 121 was observed with a urinary drainage container without a privacy cover. The DSD stated that a privacy bag should be in place to maintain resident dignity and (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	acknowledged that the absence of a privacy cover is a dignity concern and could be embarrassing for the resident. The DSD further stated that all CNA's receive in-service training and education on maintaining resident dignity, and that this is included as part of staff competencies. 2. During a review of Resident 93's admission Record (AR), the AR indicated Resident 93 was readmitted to the facility on [DATE] with a diagnosis quadriplegia (total loss of movement and sensation in all four limbs) and anxiety disorder (persistent fear or worry). During a review of Resident 93's History and Physical (H&P)ˆsigned andˆdatedˆ8/25/2025, indicated that Resident 93 was able to make decisions for activities of daily living (ADL – basic activities required for care such as eating and bathing). During a review of Resident 93's Minimum Data Set (MDS – a federally mandated resident assessment tool) datedˆ3/23/2026, Resident 93's cognition (thinking) was intact. During an observation of Resident 93's room on 4/6/2026 at 12:11 PM, Resident 93 was observed in his room with his lunch tray. During the observation, CNA 4 was assisting the resident with feeding while standing and was not positioned at the resident's eye level. During an observation of Resident 93's room on 4/7/2026 at 12:05 PM, Resident 93 was observed in his room with his lunch tray. During the observation, CNA 4 was feeding the resident while standing and not at the resident's eye level. During an observation of Resident 93 room on 4/8/2026 at 7:42 AM, Resident 93 was observed during breakfast. During the observation, CNA 4 was feeding the resident while standing and was not positioned at the resident's eye level. During an interview on 4/8/2026 at 8:00 AM with CNA 4, CNA 4 stated she understood the expectation to position herself at the resident's eye level while assisting with feeding. CNA 4 stated that Resident 93 had expressed a preference for her to remain standing. CNA 4 stated she acknowledged that she did not offer or attempt to sit at the resident's eye level while providing feeding assistance. During an interview on 4/8/2026 at 8:23 AM with the Director of Staff Development (DSD), the DSD stated that staff are expected to promote resident dignity by positioning themselves at the resident's eye level during feeding, and that not doing so is not consistent with facility expectations for maintaining resident dignity. The DSD stated that CNA 4 did not promote resident dignity while providing feeding assistance for Resident 93. During a review of the facility's Policy and Procedures (P&P) titled Quality of Life – Dignity revised on 2/2020, indicated each resident shall be cared for in a manner that promotes and enhances his or her sense of well-being, level of satisfaction with life, feeling of self-worth and self-esteem. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility's policy and procedure (P&P) titled, Quality of Life – Dignity , dated 02/2020, P&P indicated each resident shall be cared for in a manner that promotes and enhances his or her sense of well- being, level of satisfaction with life, feeling of self- worth and self-esteem. Further indicating demeaning practices and standards of care that compromise dignity is prohibited. P&P indicated staff are responsible for ensuring urinary drainage bags or containers are kept covered to promote and maintain resident dignity.

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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 observation, interview, and record review, the facility failed to obtain an informed consent for psychotropic/psychotherapeutic (any drug that affects behavior, mood, thoughts, or perception) drug for one of five sampled resident (Resident 14) who was prescribed Zyprexa (medication used to treat a mental illness that causes disturbed or unusual thinking, loss of interest in life, and strong or inappropriate emotions). This deficient practice had violated Resident 14's rights to be informed when choosing the type of care or treatment to be received, make informed decisions on alternative measures the resident or responsible party preferred, which can negatively affect Resident 14's quality of life. Findings : During a review of the admission record indicated Resident 14 was originally admitted to the facility on [DATE] and readmitted on [DATE] diagnoses that included encephalopathy (a change in how brain functions), dementia (a group of related symptoms associated with an ongoing decline of the brain and its abilities), and c) schizoaffective disorder (mix of disordered thinking, hallucinations) and severe mood swings (depression or mania). During a review of Minimum Data Set (MDS - a resident assessment tool), dated 3/16/2026, indicated Resident 14's cognitive status (the mental process of thinking and understanding) status was severely impaired. The MDS indicated Resident 14 required supervision with eating, and dependent (helper does all the effort) bathing, toileting personal hygiene and dressing. During a review of Resident 14's facility document Order Summary Report (OSR), dated 4/7/2026, the document indicated physician orders for: a) Zyprexa 2.5 mg (unit of weight) to give 1 two times a day, and b) Zyprexa 10 mg to give 1 at bedtime. During an observation on 4/7/2026 at 9:25 AM, in Resident 14's room, Resident 14 was in bed and did not respond to interview and had flat affect (reduced ability to show emotions outwardly). During a concurrent interview and record review, on 4/7/2026, at 9:35 AM, with Social Service Director (SSD), Resident 14's Electronic Health Records (EHR) was reviewed from readmission to the facility on 3/2/2026 to present 4/7/2026. The EHR did not have any documentation that informed consent for the psychotropic medications Zyprexa was obtained by the prescriber. SSD stated, aside from Resident 14's EHR, she also checked the SSD consent binder, and she could not see any documentation informed consent for the Zyprexa was obtained by the prescriber. During a concurrent interview and record review, on 4/7/2026, at 9:51 AM, with the Assistant Director of Nurses (ADON), Resident 14's electronic Health Records (EHR) was reviewed from readmission 3/2/2026 until present 4/7/2026 was reviewed. The EHR did not have any documentation that informed consent for the psychotropic medications Zyprexa was obtained by the prescriber. ADON stated, aside from Resident 14's EHR, she also checked the consent binder in the nurse's station, and she could not see any documentation informed consent for the Zyprexa was obtained by the prescriber. ADON stated, when Resident 14 was readmitted on [DATE], a new consent should have been obtained by the physician, not having an informed consent for the Zyprexa, which was a psychotropic drug was a violation of Residents rights. During an interview on 4/7/2026, at 11:43 AM, with Director of Nurses (DON), the DON stated, the facility did not have informed consent for Resident 14's Zyprexa. DON stated, it was very important to have an informed consent from Resident 14 or the Responsible Party (RP) from the physician, so reasons, benefits, risk and alternatives in using the medication are disclosed for the Resident or the RP to have an informed decision. DON stated, not having an informed consent for psychotropic medications violates resident rights. A review of the facility's policy and procedure (P&P) Informed Consent for Psychotropic Drugs (undated), indicated: a) definition of Informed Consent - disclosure of material information such as reasons, benefits, risk and alternatives to the Resident or their responsible party allowing them to accept, refuse or revoke consent, b) only Physician may obtained informed consent for antipsychotics, c) document consent in the resident's record, d) for verification a signed Consent Form for Psychotherapeutic Drug Use. A review of the facility's policy and procedure (P&P) titled Resident Rights dated 2001, indicated: a) Federal and state (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	law guarantee certain basic rights to all the residents in the facility, b) resident rights include: the right to be notified of their medical condition and of any changes in their condition, and the right to be informed of , and participate in their treatment.

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. Based on observations, interviews, and records facility failed to notify the primary physician for significant change in condition to one of one sampled resident (Resident 140) who refused to have the laboratory blood test drawn for PT (Prothrombin time) / INR (International Normalized Ratio-a test that measures how quickly blood clots) for three consecutive days (3/31/2026, 4/1/2026 and 4/2/2026) while on warfarin (a medication use as blood thinner to prevent development of blood clots) therapy for chronic pulmonary embolism (life-threatening condition due to sudden blockage in the arteries in the lungs). In addition, the facility did not have notify the physician that Resident 140 did not receive Warfarin on 4/1/26 and 4/2/26 due to refusal of blood draw in accordance with the facility's policy and procedures. As a result of this deficient practice Resident 140 was at risk for in blood clot formation that could lead to pulmonary embolism, stroke (a condition due to interruption of blood in the brain due to blood clot) or heart attack (a condition interruption of blood flow in the heart due to blood clot) resulting in death. Findings During a review of Resident 140's admission Record indicated the facility admitted Resident 140 on 3/27/2026 with diagnoses that included chronic respiratory failure (CRF) (a long-term condition that happens when your lungs cannot get enough oxygen into your blood), chronic obstructive pulmonary disease (COPD) (lung disease causing restricted airflow and breathing problems), severe obesity (abnormal or excessive fat accumulation that presents a risk to health) and chronic pulmonary embolism (a long-term condition where blood clots in the lung arteries do not dissolve, causing scarring, reduced blood flow, and high blood pressure in the lungs). During a review of Resident 140's Minimum Data Set (MDS - a resident assessment tool), dated 4/2/2026, indicated Resident 140's cognitive status (ability to think and reason) was intact. The MDS indicated Resident 140 required supervision or touching assistance (Helper provides verbal cues and or touching steadying) with eating, and substantial/maximal assistance (helper does more than half the effort) with toileting, personal hygiene and dressing. During a review of Resident 140's medication administration record (MAR) did not indicate Resident 140 received Warfarin on 4/1/2026 to 4/2/2026. During a review of Resident 140's Order Summary Report (OSR) order dated 3/29/2026 indicated: PT and INR to be drawn on 3/31/2026 result to pharmacy as soon as possible for Warfarin dose. During a review of Resident 140's Order Summary Report (OSR) order dated 4/2/2026 indicated: stat (immediately) PT and INR. During a concurrent observation and interview on 4/7/2026 at 1:30 PM with Resident 140, in Resident 140's room Resident 140 stated, she was not given Warfarin a few days ago but does not remember the day, and verbalized concern about her health to the nurses. Resident 140 also stated, she had refused her blood draw a few times because the female phlebotomist (a trained healthcare professional who draws blood from patients for medical testing) pulls and twist her arm, and she had mentioned it to the nurses but cannot remember who she reported it to. During a concurrent interview and record review on 4/7/2026 at 4:45 PM with the Assistant Director of Nurses (ADON), Resident 140's MAR dated 3/28/2026 up to 4/7/2026 indicated Resident 140 did not received Warfarin on 4/1/2026 and 4/2/2026. The PN indicated Resident 140 had refused blood draw for PT and INR for the 3rd day (4/2/2026). ADON stated, Resident 140 did not receive 2 doses of Warfarin on 4/1/2026 and 4/2/2026. Resident 140 refused blood draw on 3/31/2026, 4/1/2026 and 4/2/2026. ADON stated, PT and INR lab results are used as an ongoing monitoring to dose the Warfarin. ADON stated, there was no documentation that the primary physician was informed of Resident 140's refusal for blood draw of PT and INR for 3 days and that Resident 140 did not receive Warfarin for 4/1/2026 and 4/2/2026 until 4/2/2026 at 1:46 PM. ADON stated, the primary physician should have been notified of Resident 140s refusal of blood draw and that resident did not receive Warfarin as ordered by the physician because the Warfarin dosing was based on the result of the PT/INR. The ADON stated since the the physician was not informed about Resident 140's refusal of blood draws and not receiving Warfarin on 4/1/2026 (continued on next page)

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	055899	A. Building B. Wing	04/09/2026

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	and 4/2/2026 the Resident 140 had the potential to develop blood clot that could jeopardize Resident 140's health and safety. During an interview on 4/7/2026 at 5:30 PM with Licensed Vocational Nurse (LVN) 6, LVN 6 stated he did not notify the primary physician when Resident 140 refused Warfarin medication for 4/1/2026 and 4/2/2026 because Resident 140 refused her lab draw consecutive day and warfarin dosing depends on the PT and INR Results. LVN 6 stated, he did not notify the physician about the Resident 140 refusal of blood draw and Resident 140 not getting Warfarin on 4/1/2026 and 4/2/2026 because he thought the supervisor already reported it. During an interview on 4/9/2026 at 8:15 AM with the Director of Nurses (DON), DON stated PT and INR lab results is part of an ongoing monitoring to dose Resident 140's Warfarin. DON stated, Resident refusing PT and INR lab draw should have been reported to the physician immediately, a change of condition (COC) should have been initiated, especially if it resulted in Resident 140 not receiving the Warfarin on 4/1/2026 and 4/2/2026 potentially could result in stroke, heart attack or death. A review of the facility's policy and procedure (P&P) titled, Resident Refusal of Care and Treatment Policy (undated), indicated: a) Immediately notify physician for high-risk refusals such as medications and/or treatments, b) Ongoing monitoring - report concerns promptly. A review of the facility's policy and procedure (P&P) titled, Change in a Residents Condition or status dated 2001, indicated: a) the facility promptly notifies the resident attending physician or provider of changes in resident's condition and/or status.

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure 1 of 6 sampled residents (Resident 30) was free of unnecessary physical restraints (any manual method that is attached or adjacent to a residents body that restricts freedom of movement or ability to move independently) in accordance with the facility's policy and procedure titled Use of Restraints. Resident 30 was observed with pillows on both sides of the bed tucked under mattress sheet creating a concave surface which restricted Resident 30's ability to reposition self independently. This deficient practice has the potential for increased risk for pain, decreased range of motion, and loss of functional mobility from restricted freedom of movement and inability to independently reposition. During a review of Resident 30's admission Record indicated the resident was originally admitted to the facility on [DATE], with a diagnosis that included Dementia (a decline in memory, thinking , and ability to make decisions), history of fall, and adult failure to thrive(when an adult experiences a general decline in health, including weight loss, poor appetite, weakness, and decreased ability to function) . During a review of Resident 30's Minimum Data Set (MDS - a federally mandated resident assessment tool) dated 03/31/ 2026 , indicated resident 30 had severe cognitive impairment (confused, trouble remembering things, unable to make decisions or participate with daily task) and requires total dependence on staff to perform activities of daily living such as eating, toileting and all personal hygiene. MDS indicates resident requires maximal assistance when rolling left and right. During a review of Resident 30's Nursing Fall Risk dated 03/29/2026, indicated, Resident 30 was a high fall risk, with a score of 12. During a concurrent interview and record review on 4/9/2026 AT 3:09AM with DON, Resident 30's care plans were reviewed. Assistant Director of Nursing (ADON) indicated the resident had no care plan developed for the use of pillows or for the use of any device classified as a physical restraint. During a Review of Resident 30's active Order Summary Report for February 2026 to present (4/6/26) indicated there were no documented evidence the physician ordered Resident 30 use of pillow on both side of the bed or a physical restraints or position devices that would limit the Resident 30's ability to roll, turn, or reposition themselves independently. During an observation on 4/6/2026 at 9:02 AM in Resident 30's room, Resident 30 was observed lying in bed on her right side, with multiple pillows placed on both sides under the sheets, creating a concave surface and forming a barrier along each side of the bed. Resident 30's legs were dangling off the right side of bed. Resident 30 was observed repeatedly attempting to raise her head and upper body in an effort to reposition but was unable to do so falling back onto the bed after each attempt. This pattern of attempting to get up and fall back onto the bed continued repeatedly, until the resident ceased attempting to reposition from approximately 9:02 AM to 9: 26 AM on 4/6/2026, Resident 30 remained in this condition without staff assistance. During a concurrent observation and interview on 4/6/2026 at 09:26 AM with Certified Nursing Assistant (CNA 6) in Resident 30's room, Resident 30 was observed in bed with multiple pillows placed bilaterally under the sheets, creating a barrier. The position formed a concave surface, restricting resident to roll to the left or right side or reposition over the elevated area of bed. CNA 6 stated Resident 30 has dementia and was confused and tried to get out of bed frequently. CNA 6 further stated Resident 30 was not able to use the call light and was not alert enough to know how to use it. CNA 6 stated that when she arrived on duty at 7AM, the pillows were already in place. CNA 6 stated she informed the Assistant Director of Staff Development (ADSD) regarding the pillow positioning and was instructed to leave the pillows in place due to the resident attempting to get out of bed. CNA 6 stated that using pillows in this manner would be considered a restraint. During a concurrent observation and interview on 4/6/2026 at 9:35 AM with Director of Staff Development (DSD) in Resident 30's room, Resident observed lying on right side, unable to reposition herself with feet dangling off the edge of bed with multiple pillows noted placed under the sheets, creating a (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	barrier that restricted Resident 30' s ability to move and reposition. DSD stated that the pillows appeared to be used to prevent the resident from getting out of bed and further stated that if the pillow were being used for repositioning, they would not be placed in this manner. DSD stated Resident 30 would not be able to get out of bed or reposition because the pillows position restricted her from getting out of bed or reposition freely. The DSD Stated that the pillows were being used for fall prevention and to prevent the resident from getting out of bed. DSD continued to state that the use of restraints requires a physician's order and resident consent, as it involves resident rights. During a interview on 4/9/2026 at 03:09 PM with Assistant Director of Nursing (ADON), ADON stated pillows are not permitted to be used in a manner that restricts movement and or limits the resident's ability to move freely, further stated this would be considered a restraint. ADON stated a restraint requires a care plan and because the pillow is restricting her autonomy is a violation of her rights and has the potential for resident harm. During a review of the facility's policy and procedure (P&P) titled Use of Restraints dated 04/2017, the P&P indicated, restraints shall only be used for the safety and well - being of the resident and only after other alternatives have been tried unsuccessfully. Restraints shall only be used to treat the resident's medical symptoms(s) and never for discipline or staff convenience, or for the prevention of falls. Restraints shall only be used upon the written order of a physician and after obtaining consent from the resident and / or representative (sponsor). The order shall include the following. The specific reason for the restraint (as it relates to the resident's medical symptom). How the restraint will be used to benefit the resident's medical symptom. The type of restraint.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to develop and implement a comprehensive, resident-centered care plan (CP, a document that outlines the facility's plan to provide personalized care to a resident based on the resident's needs) for two of three sampled residents: 1. Resident 22, who was assessed as high risk for wandering. Resident 22's care plan included generalized interventions that were not individualized or specific to effectively address or prevent the resident's continued wandering throughout the facility. 2. Resident 141, who had a history of epilepsy (a brain condition that causes recurring seizures [abnormal electrical activity in your brain]) that addressed the risks for injury. The resident CP did not specify the interventions on how to keep the place safe and hazard free. These deficient practices had the potentials to affect Resident 22 by increasing the risk of elopement (a situation in which a resident leaves the premises or a safe area without the facility's knowledge and supervision), injury (including falls), exposure to unsafe environments, and unmet supervision needs, resulting in potential harm to Resident 22's safety and well-being; and affect the provision of necessary care and services for Resident 141 and result in Resident 141 sustaining an injury while a seizure occurs before nursing staff attends it. Findings: 1. During a review of Resident 141's admission Record (AR), the AR indicated that Resident 141 was initially admitted on [DATE] and readmitted on [DATE] with diagnoses including metabolic encephalopathy (a series of neurological disorders resulting from systemic illness), end stage renal disease (ESRD- irreversible kidney failure), and epilepsy. During a review of Resident 141's Minimal Data Set (MDS- a federally mandated resident assessment tool) dated 3/22/2026, the MDS indicated that Resident 141 is taking anticonvulsant (help treat epilepsy and other causes of seizures). The MDS also indicated that Resident 141 was cognitively modified independent (able to organize daily routines and make safe decisions in familiar situations but experienced some difficulty in decision-making when faced with new tasks or situations) on daily decision making, and Resident 141 required substantial/maximal assistance (helper does more than half the effort) in toilet and personal hygiene. During a review of Resident 141's Order Summary Report (OSR), dated 4/2/2026, the OSR indicated a physician order for staff to monitor staff to Resident 141's episodes of seizure(s), and keep place safe and hazard free. During a review of Resident 141's Care Plan (CP) related to the resident's seizure disorder dated 1/20/2026, the CP indicated interventions that included to keep the place safe and hazard free, and to protect the resident from injury. The CP did not specify how to keep the place safe and hazard free, including assistive devices such as padded side rails and ensuring the resident's bed was kept at the lowest position. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent observation and interview on 4/8/2026 at 10:40 AM with Certified Nurse Assistant (CNA) 8 at Resident 141's bedside, the resident's bed was not at the lowest position. CNA 8 stated that the resident's bed was not kept at the lowest position. CNA 8 stated that she was not familiar with Resident 141's risk for injury and was not instructed by the licensed nursing staff on how to keep the place safe during a seizure episode. During a concurrent record review and interview on 4/8/2026 at 4 PM with Registered Nurse (RN) 2, Resident 141's CP dated 1/20/2026 were reviewed. RN 2 stated Resident 141's CP was not individualized, and no daily routine protective measures were specified in the CP interventions for staff to consistently follow. During a concurrent observation and interview on 4/8/2026 at 4:30 PM with RN 2 at Resident 141's bedside, Resident 141 was lying in bed with no bedrails on, a BiPap machine (a type of device that helps with breathing) was on the bedside cabinet next to her head, an IV pole with a feeding pump was on her left hand side, and Resident 141's bed height was approximately at the waist level of RN 2. RN 2 stated that Resident 141 should have been provided protection in case seizure occurs such as padded bedrails and the resident's bed should have been placed at the lowest position for safety. During an interview on 4/9/2026 at 2:05 PM with the Director of Nursing (DON), the DON stated that each resident needs to have a comprehensive CP developed following resident assessment and include measures and process that can be used on the resident and available for staff who have responsibilities for providing care to the resident. The DON also stated that RN Supervisors were supposed to include high risk residents such as seizure precautions during daily huddle and ensure that assigned CNAs are aware of the interventions to keep the resident safe. During a review of the facility's policy and procedures (P&P) titled Using the Care Plan revised in 8/2006, the P&P indicated the following: The care plan shall be used in developing the resident's daily care routines and will be available to staff personnel who have responsibility for providing care or services to the resident. The Nurse Supervisor uses the care plan to complete the CNAs daily/weekly work assignment sheets and/or flow sheets. CNAs are responsible for reporting to the Nurse Supervisor any change in the resident's condition and care plan goals and objectives that have not been met or expected outcomes that have not been achieved. During a review of the facility's policy and procedures (P&P) Safety and Supervision of Residents revised in 07/2017, the P&P indicated that resident safety and supervision and assistance to prevent accidents are facility-wide priorities. The P&P also indicated the following: Individualized, resident-centered approach to safety addresses safety and accident hazards for individual residents; interdisciplinary care team shall analyze information obtained from assessments and observations to identify any specific accident hazards or risks for individual residents; the care team shall target interventions to reduce individual risks related to hazards in the environment, including adequate supervision and assistive devices; implementing interventions to reduce accident risks and hazards shall include communicating specific interventions to all relevant staff. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. During a review of Resident 22's admission Record (AR), the AR indicated was readmitted to the facility on [DATE] with diagnosis that included dementia (decline in mental ability such as memory, thinking and reasoning), psychosis (loss of reality), and insomnia (inability to fall or stay asleep). During a review of Resident 22's History and Physical (H&P)ˆsigned andˆdatedˆ2/18/2026, indicated that Resident 22 had fluctuating capacity (a person's ability to think or make decisions changes over time). During a review of Resident 22's Minimum Data Set (MDS – a federally mandated resident assessment tool) datedˆ2/21/2026, Resident 22's cognition (thinking) was severely impaired. During a review of Resident 22's CP titled High Risk for potential episodes of wandering/entering other room/offices related to cognitive impairment, dated 2/24/2026, the care plan indicated under goals that Resident 22 will demonstrate improved environmental orientation with verbal cues or reminders. The care plan indicated interventions that staff would provide reorientation to time, place and surroundings, use reassuring redirection when Resident 22 is observed near other rooms, and monitor the resident's whereabouts. During a review of Resident 22's Nursing Progress Note (NPN), dated 3/16/2026 at 9:30 PM, the NPN indicated that Resident 22 was on monitoring for wandering related to her dementia, was redirected back to her room and had many episodes of wandering during the shift. During a review of Resident 22's NPN, dated 3/17/2026 at 11:09 PM, the NPN indicated that Resident 22 was redirected back to her room and had many episodes of wandering throughout the shift. During an interview on 4/7/2026 at 11:45 AM with Certified Nursing Assistant (CNA) 2, CNA 2 stated that on 4/4/2026, she had observed Resident 22 wandering throughout the facility despite several attempts at redirection. The CNA 2 further stated that staffing was insufficient to adequately supervise Resident 22 and prevent continued wandering. During an interview on 4/9/2026 at 9:49 AM with Registered Nurse (RN) 4, RN 4 stated that Resident 22 had a diagnosis of dementia and was at high risk for wandering and elopement. RN 4 stated that Resident 22 frequently wandered throughout the facility and required ongoing redirection/monitoring. During a concurrent interview and record review on 4/9/2026 at 9:55 AM with RN 4, Resident 22's CP titled High Risk for Wandering was reviewed. RN 4 stated that the interventions such as reorientation and redirection were in place; however, these interventions were not effective, as the resident continued to wander. RN 4 acknowledged that the CP was not sufficiently resident-centered and did not adequately address the resident's individualized wandering behaviors and needs. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 4/9/2026 at 10:20 AM with the Assistant Director of Nursing (ADON), Resident 22's CP titled High Risk for Wandering was reviewed. The ADON stated that the CP interventions for Resident 22 were too general and lacked specific, individualized approaches to prevent or reduce the resident's wandering. The ADON further stated that the absence of specific interventions placed the Resident 22 at risk for injury, including falls and accidents. The ADON stated that due to insufficient staffing on 04/04/2026, Resident 22 was not adequately supervised to prevent wandering, increasing the risk for potential harm. During a review of the facility's Policy and Procedures (P&P) titled Using the Care Plan revised 8/2006, the P&P indicated that the care plan shall be used in developing the resident's daily care routines and will be available to staff personnel who have responsibility for providing care or services to the resident. The P&P indicated that CNAs are responsible for reporting to the nurse supervisor any change in the resident's condition and care plan goals and objectives that have not been met or expected outcomes that have not been achieved. During a review of the facility's P&P titled Care Plans – Baseline revised 3/2022, the P&P indicated that the baseline CP includes instructions needed to provide effective, person-centered care of the resident that meet professional standards of quality care and must include the minimum healthcare information necessary to properly care for the resident.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure one of eight sampled residents (Resident 17) had a correct identification (ID) band that was not attached to the right-side bed rail of the resident, in accordance with professional standards of practice. This failure had the potential to place the resident at risk for receiving the wrong medication, the wrong meal, and incorrect treatments. Findings: During review of Resident 17's face sheet, the face sheet indicated the resident was admitted on [DATE], with the diagnoses that included hemiplegia (severe weakness, stiffness or total loss of movement on one side of the body), encephalopathy (a malfunction that alters brain function) and epilepsy (a chronic brain disorder characterized by recurring, unprovoked seizures caused by sudden, abnormal electrical activity). During a review of Resident 17's Minimum Data Set (MDS- standardized, comprehensive assessment form used to record a resident's physical, mental, and social health status) dated 7/2/2022, the MDS indicated the resident has severe cognitive impairment. MDS also indicated Resident 17 is dependent of staff for all activities of daily living such as basic, routine tasks people do every day to care for themselves, such as bathing, dressing, eating, and moving around. During a concurrent observation and interview on 4/7/2026 at 10:49 a.m. with Assistant Director of Nursing (ADON), in Resident 17's room, Resident 17 was lying in bed with their head elevated at a 45-degree angle. An incorrect ID band was attached to the right-side bed rail of Resident 17. The ADON stated that the ID band attached to the bed rail belonged to a different resident. The ADON also stated that having the incorrect ID band could result in the resident receiving the wrong medication, the wrong diet, and overall incorrect care. During an interview on 4/9/2026 at 9:47 a.m. with Director of Nursing (DON), DON stated, that having the wrong ID band on a resident's bed rail could confuse staff and potentially result in the resident receiving the wrong care. During a review of the facility's policy and procedure (P&P) titled Resident Identification System, dated 2001, the P&P indicated photo and/or wristband identification are used by nursing service personnel when administering medications and treatments

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure that one of three sampled residents (Resident 11) with limited range of motion (ROM- the extent of movement of a joint) on his left fourth (4th) and fifth (5th) fingers received appropriate treatment and services to maintain mobility and/or improve mobility by failing to ensure: 1. The certified nurse assistants (CNAs) assigned to Resident 11 reported to the licensed staff in charge of the resident's decline in ROM during daily care. 2. The licensed nurse completed a change of condition (COC) report and developed a Care Plan (CP) to prevent/minimize contractures (a stiffening/shortening at a joint, that reduces the joint's range of motion) as indicated in the resident's care plan and in the facility's policy. This deficient practice resulted in delaying rehabilitative services to Resident 11 and leaving Resident 11's function declined, pain, and discomfort. Findings: During a review of Resident 11's admission Record, the AR indicated that Resident 11 was originally admitted on [DATE] and readmitted on [DATE] with diagnoses that included diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing), anemia (a condition where the body does not have enough healthy red blood cells), and adult failure to thrive (a decline caused by chronic diseases and functional impairments which can cause weight loss, decreased appetite, poor nutrition, and inactivity). During a review of Resident 11's Order Summary Report (OSR), dated 7/25/2025, the OSR indicated a physician order that the resident may participate in restorative nursing care (or RNA- formal, planned and organized program of care which is intended to restore a lost ability or maintain the highest level of function of the long term care residents). During a review of Resident 11's Minimal Data Set (MDS- a federally mandated resident assessment tool), datedˆ1/30/2026, the MDSˆindicatedˆResident 11 needed supervision or touching assistance (helper provides verbal cues and/or contact guard assistance as resident completes activity) on eating (the ability to use suitable utensils to bring food and/or liquid to the mouth andˆswallow food and/or liquid once the meal is placed before the resident) and the resident needed substantial assistance (helper does more than half the effort) on upper and lower body dressing.ˆ The MDS also indicated that Resident 11 did not have functional limitation in range of motion on both upper extremities. During a review of Resident 11's Care Plan (CP) titled At risk for falls/injuries, skin breakdown, and functional and nutritional decline, revised on 2/27/2026, the interventions included to observe and report changes in usual routine, sleep patterns, decrease in functional abilities, decrease in ROM, withdrawal or resistance to care. During a review of Resident 11's Nursing Progress Notes (NPN), dated from 10/1/2025 to 4/6/2026, there was no documented evidence indicating that Resident 11's left fourth and fifth fingers with limited ROM were identified. During a concurrent observation and interview on 4/7/2026 at 9:32 AM with Resident 11, Resident 11 presented to the surveyor his left hand demonstrating that his fourth and fifth fingers were bending inward toward the palm and cannot be fully straightened. Resident 11 stated his fingers have been painful and stiff for a couple of months. Resident 11 stated, he has reported the issue to his nurse, but he was only provided with pain medication, and he was never seen by any doctor or received any therapy. During a concurrent observation and interview on 4/7/2026 at 9:40 AM with CNA 9, CNA 9 stated he noticed Resident 11's left fourth and fifth fingers' stiffness a while ago that he could not recall first time noticing. CNA 9 stated he was supposed to report the resident's fingers issue to the licensed nursing staff immediately when he noticed it. During a concurrent interview and record review on 4/8/2026 at 12:59 PM with Licensed Vocational Nurse (LVN) 4, Resident 11's NPN and CP dated from 2/27/2026 to 4/6/2026, were reviewed. LVN 4 stated Resident 11 did not have RNA services for his left fourth and fifth fingers at this time. LVN 4 stated CNA 9 or any CNA was supposed to observe the resident's functional mobility decline and notify her. LVN 4 stated she did not properly assess to recognize Resident 11's decline in ROM (stiffness) in his left fourth and fifth (continued on next page)

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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 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	fingers because she thought it was just how the resident's fingers look when holding things. During an interview on 4/9/2026 at 2:25 PM with the Director of Nursing (DON), the DON stated that nursing staff were responsible to assess the resident daily and report if they see anything that may be a concern. The DON stated, not assessing and reporting functional decline of Resident 11's stiff and contracted left fourth and fifth fingers placed the resident at high risk for further decline and irreversible loss of mobility. During a review of the facility's policy and procedures (P&P) titled Resident Mobility and Range of Motion revised in 7/2017, the P&P indicated the following: Residents will not experience an avoidable reduction in range of motion (ROM). Residents with limited range of motion will receive treatment and services to increase and/or prevent a further decrease in ROM. Residents with limited mobility will receive appropriate services, equipment and assistance to maintain or improve mobility unless reduction in mobility is unavoidable. As part of the comprehensive assessment, the nurse will also identify conditions that place the resident at risk for complications related to ROM and mobility. During the resident's assessment, the nurse will identify the underlying factors that contribute to his or range of motion or mobility problems, if any, including: a. Immobilization (bedfast, chair or wheelchair usage); b. Neurological conditions (e.g. cerebral palsy, cerebral-vascular accident, etc.); c. Conditions in which movement may lead to pain; and/or d. Conditions that limit or immobilize movement of limbs or digits (e.g., splints)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide a hazard free environment to one of three sampled residents (Resident 141), who had a history of epilepsy (a brain condition that causes recurring seizures [abnormal electrical activity in your brain]) when Resident 141's bed had no padded side rails and was not kept at the lowest position on 4/8/2026. This deficient practice had the potential to result in Resident 141's injury in the event of falls while a seizure occurs. Findings: During a review of Resident 141's admission Record (AR), the AR indicated that Resident 141 was initially admitted on [DATE] and readmitted on [DATE] with diagnoses including metabolic encephalopathy (a series of neurological disorders resulting from systemic illness), end stage renal disease (ESRD- irreversible kidney failure), and epilepsy. During a review of Resident 141's Care Plan (CP) that focused on the resident's seizure disorder, dated 1/20/2026, the CP indicated interventions that included to keep the place safe and hazard free, and to protect the resident from injury. The CP did not specify how to keep the place safe and hazard free or how to protect the resident from injury. During a review of Resident 141's Minimal Data Set (MDS- a federally mandated resident assessment tool), dated 3/22/2026, the MDS indicated that Resident 141 is taking anticonvulsant (help treat epilepsy and other causes of seizures). The MDS also indicated that Resident 141 was cognitively modified independent (The person organized daily routines and made safe decisions in familiar situations) on daily decision making. During a review of Resident 141's Order Summary Report (OSR), dated 4/2/2026, the OSR indicated a physician order for staff to monitor Resident 141's episodes of seizure(s), and keep place safe and hazard free. During a review of Resident 141's CP that focused on the resident risk for altered cognitive status with the risk factors that included risk for falls and injury, dated 4/6/2026, the CP indicated the goal was for Resident 141 to maintain the highest possible level of cognitive function and remain free from injury. The CP indicated the interventions that included to implement safety and fall precautions. The CP did not specify what precautions that staff should follow to provide safety and prevent the resident from falling. During a concurrent observation and interview on 4/8/2026 at 10:40 AM with Certified Nurse Assistant (CNA) 8 at Resident 141's bedside, the resident's bed was not at the lowest position. CNA 8 stated that the resident's bed was not kept at the lowest position. CNA 8 stated that she was not familiar with Resident 141's risk for injury and was not instructed by the licensed nursing staff on how to keep the place safe during a seizure episode. During a concurrent record review and interview on 4/8/2026 at 4:00 PM with the Registered Nurse (RN) 2, Resident 141's clinical records were reviewed. RN 2 stated Resident 141's Care Plan was supposed to cover frequency of rounding to monitor the resident for episode of seizure, and protective assistive devices that can be applied surrounding Resident 141. During a concurrent observation and interview on 4/8/2026 at 4:30 PM with RN 2 at Resident 141's bedside, Resident 141 was lying in bed with no bedrails on, a BiPap machine (a type of device that helps with breathing) was on the bedside cabinet next to her head, an IV pole (essential medical devices designed to securely hold fluid bags and pumps) with a feeding pump was on her left hand side, and Resident 141's bed height was approximately at the waist level of RN 2. RN 2 stated that Resident 141 should have been provided protection in case seizure occurs such as padded bedrails, floor mat and that the resident's bed should have been placed at the lowest position for safety. During the same interview on 4/8/2026 at 4:30 PM with RN 2, RN 2 stated in the event that Resident 141 had a seizure, she could fall from bed, and her head could hit any of the equipment, which could lead to injury. RN 2 stated staff were supposed to perform evaluation and analysis of hazards and risks, and implement individualized, resident-centered interventions since the resident was admitted . During an interview on 4/9/2026 at 2:05 PM with the Director of Nursing (DON), the DON stated that Resident 141's CP should have been individualized, resident-centered to specify adequate seizure precaution (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	measurement and padding devices, so the resident's risks for fall and injury from seizure may be prevented. The DON also stated that RN Supervisors were supposed to include high risk residents such as seizure precautions during daily huddle and ensure that assigned CNAs are aware of the interventions to keep the resident safe. During a review of the facility's policy and procedures (P&P) Safety and Supervision of Residents revised in 07/2017, the P&P indicated that resident safety and supervision and assistance to prevent accidents are facility-wide priorities. The P&P indicated: a) the facility individualized, resident-centered approach to safety addresses safety and accident hazards for individual residents; b) interdisciplinary care team shall analyze information obtained from assessments and observations to identify any specific accident hazards or risks for individual residents; c) the care team shall target interventions to reduce individual risks related to hazards in the environment, including adequate supervision and assistive devices; d) implementing interventions to reduce accident risks and hazards shall include communicating specific interventions to all relevant staff and ensuring that interventions are implemented. The P&P also indicated risk factors and environmental hazards includes bed safety. During a review of the facility's P&P titled, Falls and Fall Risk, Managing, revised 2018, the P&P indicated: a) environmental factors that contribute to the risk of falls include incorrect bed height or width; b) resident conditions that may contribute to the risk of falls include functional impairments and incontinence; c) medical factors that contribute to the risk of falls include neurological disorders. The P&P indicated the staff will implement a resident-centered fall prevention plan to reduce the specific risk factor(s) of falls for each resident at risk or with a history of falls.

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide medically-related social services to help each resident achieve the highest possible quality of life. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed toˆprovide medically-related social serviceˆin accordance with the facility's policy and procedure titledˆ Social Services- Referralsˆfor one of thirteen sampled residents (Residentˆ11), who had missing teeth and had requestedˆnew denturesˆ(removable oral appliances that replace missing teeth). The facility failedˆto follow up with the dental clinic for Resident 11's X-ray (a fast, painless imaging test that uses special, invisible type of light to take pictures of the inside of a human body) results and follow up with the resident's primary physician for medical clearance (an official, written authorization stating that a person is healthy enough to undergo a specific procedure) to proceed with his teeth extraction and denture fabrication procedure as recommended by the resident's dentist. The facility also failed to update Resident 11 with his request for new dentures for two months. ˆ This deficient practice resulted in Resident 11'sˆfeeling ignored and not able to chew and enjoy the food of his preferences due to not receiving his new denture. This deficient practice left Residentˆ11ˆcontinuing to experience difficulty chewing with his remainingˆteeth and increased the risk of the resident not able to maintain his highest practical well-being.ˆFindings: During a review of Resident 11's admission Record, the AR indicated that Resident 11 was originally admitted on [DATE] and readmitted on [DATE] with diagnoses that included diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing), anemia (a condition where the body does not have enough healthy red blood cells), and adult failure to thrive (a decline caused by chronic diseases and functional impairments which can cause weight loss, decreased appetite, poor nutrition, and inactivity). During a review of Resident 11's Order Summary Report (OSR), the OSR indicated a diet order on 7/29/2025 of Consistent Carbohydrate (CCHO, a nutrition plan for managing blood sugar, particularly in DM, by keeping carbohydrate [one of the three main nutrients found in food and drink] intake roughly the same amount at every meal) with soft and bite size texture. During a review of Resident 11's hand-written dental notes (HWDN), dated 10/29/2025, the HWDN indicated that 14 PA X-Rays (Periapical- intraoral radiograph capturing the entire tooth, from the crown to the root apex) were taken. During a review of Resident 11's HWDN, dated 11/4/2025, the HWDN indicated that Resident 11 had multiple missing teeth. The HWDN also indicated that new dentures/partials and teeth extractions (teeth removal) were recommended. During a review of Resident 11's Progress Notes titled Quarterly Social Services Evaluation (QSSE), dated 11/5/2025, the QSSE indicated that Resident 11 had dental hygiene rendered on 9/11/2025. There was no documented evidence indicating that the facility followed up on Resident 11's X-ray results and the process to obtain his new dentures. During a review of Resident 11's HWDN, dated 1/14/2026, the HWDN indicated that Resident 11's treatment (unspecified) has been approved, medical clearance has been requested, and the resident's treatment recommendation was XB's (Extract from bone- teeth extractions). During a review of Resident 11's dental Medical Order Form (MOF), dated 1/19/2026, the MOF indicated that Resident 11 has been authorized by Medi-Cal (California's public health insurance program for low-income residents) for full upper and lower dentures and extractions of teeth number 12, 13, 16, 23, 24, 25, 27, 29, 30, 32. The MOF indicated Physician's Medical Order Release Form section was not completed. During a review of Resident 11's Minimal Data Set (MDS- a federally mandated resident assessment tool) dated 1/30/2026, the MDS indicated Resident 11 needed supervision or touching assistance (helper provides verbal cues and/or contact guard assistance as resident completes activity) in eating (the ability to use suitable utensils to bring food and/or liquid to the mouth and swallow food and/or liquid once the meal is placed before the resident). During a review of Resident 11's Social Services Quarterly Evaluation (SSQE), dated 1/30/2026, the SSQE indicated that Resident 11 had dental X-ray performed on 10/29/2025. The SSQE did not indicated any follow-ups made by the facility to obtain (continued on next page)

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident 11's X-ray results, confirm Medi-Cal authorization, and contact the primary physician for medical clearance. During a review of Resident 11's Social Service Progress Notes (SSPN), dated from 10/1/2025 to 4/7/2026, the SSPN indicated there was no documented evidence that the facility followed up with the dental clinic regarding Resident 11's Medi-Cal treatment approval, X-ray results, and medical clearance to proceed with the resident's dental treatment for teeth extraction and denture fabrication procedure. The SSPN indicated there was no documented evidence that the facility made any attempt to update and address the resident's concerns regarding his denture's procedure. During a concurrent observation and interview on 4/7/2026 at 9:45 AM, Resident 11 had missing teeth on both upper and lower gums. Resident 11 stated that he needed dentures to chew and able to enjoy food that he preferred and Resident 11 stated he had spoken to social service personnel but never got responses for more than 2 months. Resident 11 stated he felt ignored when social services never mentioned or updated him with his denture's procedure. During a concurrent interview and record review on 4/8/2026 at 1:09 PM with the Social Service Director (SSD), Resident 11's Electronic Health Records (EHR- an electronic version of a patient's medical history) including the resident's progress notes, SSQE, and dental notes dated 10/1/2025 to 4/8/2026, were reviewed. The SSD stated she was aware that Resident 11 needed new dentures. The SSD stated that she and her designees were responsible for following up with the dentist and obtaining notes after each visit. The SSD stated they did not check in or give any updates to Resident 11 regarding his denture's fabrication procedure. The SSD stated they did not follow up after Resident 11's X-Rays or medical clearance. The SSD also confirmed that they did not discuss Resident 11's dental issues during IDT (Interdisciplinary Team- a collaborative group of health professionals working together to manage patient care) meetings. During a review of the facility's Policy and Procedures (P&P) titled Social Service- Referrals undated, the P&P indicated that social services will collaborate with the nursing staff or other pertinent disciplines to arrange for services that have been ordered by the physician. The P&P also indicated that social services will document the referral in the resident's medical record.

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F 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely, quality laboratory services/tests to meet the needs of residents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure one of three sampled residents (Resident 11) received necessary care and laboratory services to confirm diagnosis when Resident 11 experienced signs and symptoms of urinary tract infection (UTI- an infection in the bladder/urinary tract) by failing to perform in and out catheterization (a procedure used to drain the bladder and collect urine with a straight tube that is taken out right after it is used) and obtain urine specimen for urinalysis (UA- a test of urine), culture and sensitivity (C&S- the standard test for revealing the causative microorganism for a UTI) as indicated in the physician's orders. This deficient practice had the potential to delay necessary treatment to Resident 11. Findings: During a review of Resident 11's admission Record (AR), the AR indicated that Resident 11 was originally admitted on [DATE] and readmitted on [DATE] with diagnoses that included diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing), anemia (a condition where the body does not have enough healthy red blood cells), and adult failure to thrive (a decline caused by chronic diseases and functional impairments which can cause weight loss, decreased appetite, poor nutrition, and inactivity). During a review of Resident 11's Order Summary Report (OSR) dated on 4/4/2026, the OSR indicated a physician order for Resident 11 to get in and out urine for UA and CS one time for labs. During a review of Resident 11's Medication Administration Record (MAR) dated from 4/1/2026 to 4/9/2026, the MAR indicated the following: Bactrim (a common prescription antibiotic used to treat various bacterial infections) DS (double strength) Oral Tablet 800-160 MG Give 1 (one) tablet by mouth two (2) times a day for UTI (EMPIRIC [relies solely on practical experience rather than on scientific principles]) for 10 Days pending UA/CS. The MAR also indicated the order started on 4/4/2026. During a concurrent interview and record review on 4/8/2026 at 10:50 AM with Licensed Vocational Nurse (LVN) 4, Resident 11's Electronic Health Record (EHR, a digital version of a patient's paper chart, storing comprehensive medical history, notes, diagnoses, and lab results) were reviewed. LVN 4 stated that she could not find Resident 11's UA and C&S results. LVN 4 stated there was also no hard copy of Resident 11's UA and C&S results in the resident's paper chart binder kept in the nursing station. During a concurrent interview and record review on 4/8/2026 at 11:00 AM with IPN, the IPN stated he did not know if the physician order for in and out catheterization to obtain urine specimen on 4/4/2026 was completed by any LVN, and he did not follow up to ensure Resident 11's specimen was sent out to laboratory services. The IPN stated it usually took one or two days for the UA result first to come back but he did not check and follow up on them. The IPN further stated without following appropriate procedures Resident 11 could take unnecessary antibiotics, develop side effects and increase resistance to the medication. During an interview on 4/9/2026 at 2:15 PM with the Director of Nursing (DON), the DON stated the nursing staff and the IPN were supposed to follow up on Resident 11's urine specimen to ensure results were available to confirm the resident's UTI diagnosis timely adjust the antibiotic treatment if needed. The DON stated, laboratory results are every important because it can guide and confirm the correct antibiotics for the resident's treatment. During a review of the facility's Policy and Procedures (P&P) titled Lab and Diagnostic Test Results-Clinical revised in 11/2018, the P&P indicated that the physician will identify and order diagnostic and lab testing based on the resident's diagnostic and monitoring needs, and the staff will process test requisitions and arrange for tests. The P&P also indicated that a nurse will try to determine whether the test was done: a. As a routine screen or follow-up; b. To assess a condition change or recent onset of signs and symptoms; or c. To monitor a drug level. 1. The reason for getting a test often affects the urgency of acting upon the result

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. Based on observation, interview, and record review, the facility failed to prepare food by methods that conserved flavor and temperature when hot foods were not in palatable temperature and pork chops were hard and overcooked. These failures had potential to result in 124 of 127 facility residents at risk of unplanned weight loss, a consequence of poor food intake, getting food from the kitchen. Findings: During a review of the facility's menu spreadsheet (a sheet containing the kind and amount of food each diet would receive) titled Winter Menus 2026, dated 4/6/2026, the spreadsheet indicated residents on regular diet (diet with no food restriction) would include the following foods on the tray: Pork chop two (2) ounces (oz, a unit of measurement) Gravy 1 each Herbed [NAME] 1/2 cup (c, household measurement) Mixed Vegetables 1/2 c Roll/Margarine 1 each Peach cobbler 1 square Beverage 8 fluid oz During a concurrent test tray (a process of tasting, temping, and evaluating the quality of food) observation and interview on 4/6/2026 at 1:21 p.m., with the Dietary Supervisor (DS) observed the DS took the temperatures of the food using the facility thermometer. The DS stated pork chop was at 127 degrees Fahrenheit (degrees F, degree of temperature), herbed rice 110 degrees F, mixed vegetables 107 degrees F. The DS stated the temperature for hot foods was low and the food was cold. The DS stated the pork chop was dry and overcooked. The DS stated, Hot foods are expected to be served hot and if it were not, the residents would not eat the food because it was not palatable. The DS stated residents could choke on the dry pork chop as a potential outcome that could potentially lose weight for not eating the food that was not palatable to them. The DS stated the facility service wares are not insulated and they do not have plate warmers. The DS stated he mentioned getting plate warmers to the Administrator yesterday to keep hot food hot as their current wares are not holding temperatures. During a review of the facility's policies and procedures (P&P) titled Policy: Food Preparation-Conservation of Flavor, Appearance, and Temperature undated, the P&P indicated The facility shall prepare and serve food in a manner that preserves flavor, appearance, and proper temperature, ensuring meals are palatable, nutritious, and safe. Purpose: To promote resident satisfaction, nutritional intake, and food safety by ensuring high quality meal preparation and service. (1) Flavor presentation: avoid overcooking or undercooking of food. (3) Temperature Control During Preparation and Service: hot foods maintained at equal to or more than 135 degrees F. (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	. 2. During a review of Resident 2's admission Record (AR), the AR indicated the facility originally admitted Resident 2 on 06/19/2025 with diagnoses that included metabolic encephalopathy (brain disfunction caused by a problem in the body's chemistry) , chronic obstructive pulmonary disease(long term lung disease were air gets trapped in the lungs) , and malignant neoplasm (cancer growth) of upper lung. During a review of Resident 2's Minimum Data Set (MDS, a resident assessment tool), dated 03/10/2026, the MDS indicated Resident 2 was cognitively intact and without significant memory or thinking problems and required only verbal cues for all activities of daily living such as dressing, oral hygiene or toileting. During an interview on 04/06/2026 at 08:45AM with Resident 2, stated my only complaint is my food, its cold by the time I get my tray and the facility will not reheat. During a concurrent observation and interview on 04/06/2026 at 1:21 PM with Resident 2, Resident 2 was observed assessing the temperature and palatability of meal. Resident 2 stated that the vegetables were slightly warm, the meat was cold, and the rice was not palatable and would not be eaten. When asked if the resident requested staff to reheat or replace the meal, Resident 2 stated, I do not ask them to reheat the food. I just have to eat it cold. During a concurrent observation and interview on 4/6/2026 at 1:35 PM with Dietary Supervisor (DS), a test tray was sampled for temperature and palpability. The temperature of the sampled tray was: Protein measured at 127 degrees F Rice at 106 degrees F Vegetables at 107 degrees F During a continued observation and interview on 4/6/2026 at 1:35 PM DS, the DS stated the food temperatures were considered cold and not palatable and further stated serving food at these temperatures has the potential to result in residents not eating their meals. DS stated if a tray is cold, a new tray or alternative meal should be provided to the resident. During a review of the facility's policy and procedure titled, Monitoring Tray-line/Meal service Temperatures (undated) , indicated test tray monitoring will be done in accordance with established Quality Assurance Performance improvement (QAPI) schedules / procedures, to ensure that foods are properly heated/ chilled to obtain appropriate serving temperatures to the residents (over 140 degrees F for hot food and under 41 degrees F for cold foods).

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	055899	A. Building B. Wing	04/09/2026

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure staff accurately reflect actual Wander Guard (a type of wearable device used in healthcare facilities, to prevent residents from wandering or eloping) function testing documentation in one of two sampled residents (Resident 15), who was identified at risk for elopement (when a person with cognitive [thought process] impairment leaves a safe area, such as a care facility or home, without awareness of the potential dangers). Licensed Vocational Nurse (LVN) 2 did not perform Wander Guard function test but signed Resident 15's Medication Administration Record (MAR) for Monitor Wander Guard Functioning Q shift (every shift) 7-3 shift on 4/2/2026, 4/3/2026, and 4/9/2026. These deficient practices had the potential not to meet Resident 15's care needs that may lead to Resident 15's safety issues when Resident 15's Wander Guard was not tested for functioning. Findings: During a review of Resident 15's admission Record (AR), the AR indicated that Resident 15 was initially admitted on [DATE] and readmitted on [DATE] with diagnoses including metabolic encephalopathy (a series of neurological disorders result from systemic illness), bipolar disorder (sometimes called manic-depressive disorder; mood swings that range from the lows of depression to elevated periods of emotional highs), and dementia (a progressive state of decline in mental abilities). During a review of Resident 15's Minimal Data Sheet (MDS- a federally mandated resident assessment tool) dated 1/19/2026, the MDS indicated that Resident 15 required supervision or touching assistance (Helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity) on sit to stand and walking 50 feet with two turns. The MDS also indicated that Resident 15 used wander (a person that roams around and becomes lost or confused about their location)/elopement alarm daily. During a review of Resident 15's Orders Summary Report (OSR) dated 2/5/2026, the OSR indicated the following: Apply Wander Guard to alert staff when resident attempts to go/wander out of the facility unattended every shift for safety; Monitor Wander Guard Functioning Q shift every shift. During a review of Resident 15's Medication Administration Record (MAR) dated from 4/1/2026 to 4/9/2026, the MAR indicated Monitor Wander Guard Functioning Q shift (every shift) 7-3 shift on 4/2/2026, 4/3/2026, and 4/9/2026 were signed by LVN 2. During a concurrent interview and a record review on 4/9/2026 at 12:25 PM with LVN 3, Resident 15's MAR dated from 4/1/2026 to 4/9/2026 was reviewed. LVN 3 stated Resident 15 was assigned to LVN 3 but LVN 2 signed Resident 15's MAR for LVN 3. her on the MAR. LVN 3 stated because sometimes another nurse that took the test device would check for all residents with a Wander Guard on behalf of the other nurse(s). During a concurrent interview and a record review on 4/9/2026 at 12:45 PM with LVN 2, Resident 15's MAR dated from 4/1/2026 to 4/9/2026 was reviewed. LVN 2 stated that she did not perform Wander Guard function test testing for Resident 15 this morning (4/9/2026). LVN 2 stated that she was not familiar with the Wander Guard function test device and did not know how to perform the test. LVN 2 stated that she was not supposed to sign for other nurses, but she signed on 4/2/2026, 4/3/2026, and this morning (4/9/2026) without performing Wander Guard test function test by herself. During an interview on 4/9/2026 at 2:10 PM with the Director of Nursing (DON), the DON stated staff should've checked and signed on their assigned residents' MAR on their own and never signed it on behalf of someone else since this is not appropriate and not legal. During a review of the facility's policy and procedures (P&P) titled Charting and Documentation undated, the P&P indicated that all services provided to the resident, progress toward the care plan goals, or any changes in the resident's medical, physical, functional or psychosocial condition, shall be documented in the resident's medical record. The P&P also indicated that documentation of procedures and treatments will include care-specific details, including the date and time the procedure/treatment was provided.

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement a program that monitors antibiotic use. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review, the facility failed to implement its antibiotic (medicines that fight bacterial infections) stewardship program (facility protocols for managing infections) for one of three sampled residents (Resident 11) who was prescribed Bactrim (a common prescription antibiotic used to treat various bacterial infections) DS (double strength) for suspected urinary tract infection (UTI- an infection in the bladder/urinary tract) by failing of the Infection Prevention Nurse (IPN) tracked the physician' order on 4/4/2026 for Resident 11's urine specimen collection, confirmed that the specimen was sent to laboratory, and followed up on lab results for urinalysis (UA- a test of urine), culture and sensitivity (C&S- the standard test for revealing the causative microorganism for a UTI) in a timely manner to ensure appropriate antibiotic treatment. This deficient practice had a potential for Resident 11 to increase the risk of unnecessary antibiotic use, and a potential to develop multidrug -resistant organisms (MDRO, bacteria or other germs that have developed resistance to multiple types of antibiotics) that could result in a decline in the resident's wellbeing. Findings: During a review of Resident 11's admission Record (AR), the AR indicated that Resident 11 was originally admitted on [DATE] and readmitted on [DATE] with diagnoses that included diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing), anemia (a condition where the body does not have enough healthy red blood cells), and adult failure to thrive (a decline caused by chronic diseases and functional impairments which can cause weight loss, decreased appetite, poor nutrition, and inactivity). During a review of Resident 11's Order Summary Report (OSR) dated on 4/4/2026, the OSR indicated a physician ordered to obtain Resident 11's urine specimen for urinalysis (UA and CS by In and Out catheterization (a procedure of inserting a catheter in the bladder to drain urine and the catheter is removed out when the urine completely drained) one time, and to give one 800-160 MG tablet of Bactrim DS by mouth two (2) times a day for UTI (EMPIRIC [relies solely on practical experience rather than on scientific principles]) for 10 days pending (awaiting for the results of) UA/CS. During a review of Resident 11's Infection Note written by the IPN, dated 4/5/2026, the note indicated the facility started Resident 11 on an empiric course (treatment started before diagnosis is confirmed) of Bactrim DS on 4/4/2026 for a suspected healthcare-associated infection. The note further indicated that based on Resident 11's presentation, a formal Antibiotic Timeout (a structured, formal reassessment of a resident's antibiotic therapy) should occurred at the 48-72 hours (2-3 days) mark after the initial dose was administered on 4/4/2026 for the care team to review the resident's culture results, implement de-escalation and stewardship to prevent the development of MDROs, check the duration of antibiotic therapy, and monitor for side effects of antibiotic use. During a review of Resident 11's care plan (CP) for infection prevention and control related to the resident's diagnosis of suspected UTI, dated 4/5/2026, the CP indicated the goals included that the antibiotic course will be reviewed for appropriateness (Timeout) upon receipt of UA/CS results to ensure proper stewardship, and the interventions included to monitor the lab portal for UA/CS results, and conduct a clinical review at the 48-72 hours mark to discuss de-escalation, switching to a narrow-spectrum agent or discontinuation with the physician. During a review of Resident 11's Medication Administration Record (MAR) dated from 4/1/2026 to 4/8/2026, the MAR indicated Bactrim DS was administered to Resident 11 from 4/4/2026 at 6PM to 4/8/2026 at 9AM with the total of eight (8) doses in four (4) consecutive days. During a review of Resident 11's Progress Notes, dated 4/6/2026 to 4/7/2026, there was no documented evidence that a formal Antibiotic Timeout was provided at 48-72 hours mark of the initial dose of Bactrim DS which started on 4/4/2026. There was no documented evidence that Resident 11's urine specimen was collected, sent to laboratory services and that the IPN followed up with the laboratory results. During a concurrent interview and record review on 4/8/2026 at 10:50 AM with Licensed Vocational Nurse (LVN) 4, Resident 11's Electronic Health Record (EHR, a digital version of a patient's paper chart, storing comprehensive medical (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	history, notes, diagnoses, and lab results) were reviewed. LVN 4 stated that she could not find Resident 11's UA and C&S results. LVN 4 stated there was also no hard copy of Resident 11's UA and C&S lab order in the binder kept in the nursing station meaning that such order was not received by the lab. During a concurrent interview and record review on 4/8/2026 at 11:00 AM with IPN, the IPN stated he did not know if the physician order for In and Out catheterization to obtain urine specimen on 4/4/2026 was completed by any LVN, and he did not follow up to ensure Resident 11's specimen was sent out to laboratory services. The IPN stated it usually took one or two days for the laboratory results to come back but he did not check and follow up on them. The IPN further stated without following appropriate procedures Resident 11 could take unnecessary antibiotics, develop side effects and increase resistance to the medication. During an interview on 4/8/2026 at 2:44 PM with the IPN, the IPN stated, he was responsible in monitoring the Antibiotic Stewardship Program and for conducting infection surveillance (identifying the infection in the facility), tracking residents with infections including the correct diagnosis, and ensuring laboratory results are obtained and reported to the physician as soon as possible to evaluate the necessity and efficiency of the current antibiotic treatment. During an interview on 4/9/2026 at 2:15 PM with the Director of Nursing (DON), the DON stated the nursing staff and the IPN were supposed to follow up on Resident 11's urine specimen to ensure results were available to confirm the resident's UTI diagnosis timely adjust the antibiotic treatment if needed. The DON stated, laboratory results are every important because it can guide and confirm the correct antibiotics for the resident's treatment. During a review of the facility's Policy and Procedures (P&P) titled, Antibiotic Stewardship, revised 2016, indicated when a culture and sensitivity (C&S) is ordered, lab results and the current clinical situation will be communicated to the prescriber as soon as available to determine if antibiotic therapy should be started, continued, modified, or discontinued. During a review of the facility's P&P Surveillance for Infections, revised 2017, indicated: a) The purpose of the surveillance of infections is to identify both individual cases and trends of epidemiologically significant organisms and healthcare-associated infections, to guide appropriate interventions, and to prevent future infections; b) The surveillance should include a review of laboratory records; c) For residents with infections that meet the criteria for definition of infection for surveillance, collect these data as appropriate: identifying information, diagnoses, date of onset of infection, infection site, pathogens, risks factors. During a review of the facility's P&P titled, Infection Prevention and Control Program, revised 2018, indicated: a) The infection prevention and control program is coordinated and overseen by an infection specialist (infection preventionist); b) Antibiotic Stewardship: culture reports, sensitivity data, and antibiotic usage reviews are included in surveillance activities. During a review of the facility's P&P titled, Lab and Diagnostic Test Results- Clinical revised in 11/2018, the P&P indicated that the physician will identify and order diagnostic and lab testing based on the resident's diagnostic and monitoring needs, and the staff will process test requisitions and arrange for tests. During a review of the facility's P&P titled, Infection Preventionist-LVN Job Description, dated 2021, the P&P indicated the Infection Preventionist is responsible to review and analyze infectious disease laboratory reports.

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that a working call system is available in each resident's bathroom and bathing area. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure two of eight sampled residents (Resident 122 and Resident 155) were able to utilize their call light. This failure had the potential to affect the residents' ability to request assistance when needed. Fingins: 1. During a review of Resident 122'sFace Sheet, the Face Sheet indicated the resident was admitted on [DATE], with the diagnosis that include metabolic encephalopathy (a sudden or gradual decline in brains function caused by chemical, metabolic or organ problem), epilepsy (a chronic brain disorder characterized by recurring, unprovoked seizures caused by sudden, abnormal electrical activity) and transient ischemic attack (a temporary blockage of blood flow to the brain, causing stroke like symptoms). During a review of Resident 122's Minimum Data Set (MDS- standardized, comprehensive assessment form used to record a resident's physical, mental, and social health status) dated 3/3/2025, the MDS indicated the resident has moderate cognitive impairment). 2.During a review of Resident 135'sFace Sheet, the Face Sheet indicated the resident was admitted on [DATE], with the diagnoses that include hemiplegia (severe paralysis, meaning a total loss of movement on one side), hemiparesis (partial weakness, affecting the arm, leg, and face opposite the brain) and dysarthria (a motor speech disorder caused by muscle weakness, paralysis, or lack of coordination in the mouth, face, or respiratory system). During a review of Resident 135's MDS dated [DATE], the MDS indicated the resident had moderate cognitive impairment and was dependent on staff for all activities of daily living such as basic, routine tasks people do every day to care for themselves, such as bathing, dressing, eating, and moving around. During a concurrent observation and interview on 4/6/2026 at 9:33 a.m. with Infection Preventionist Nurse (IPN) in Resident 122's room, Resident 122 was lying in bed with their head elevated at a 45-degree angle. The call light was behind the resident, on the right-side of their dresser that the resident could not reach. The IPN stated that the call light should always be within the resident's reach as failing to do so may prevent the resident from requesting assistance to meet their needs. During a concurrent observation and interview on 4/6/2026 at 11:30 a.m. with Resident 135, in Resident's 135 room, Resident 135 physically demonstrated that he could not extend his hands out, to activate the call light. Resident 135 stated, that he was unable to call for assistance because he did not have the strength to press the call light pad with either hand. During an interview on 4/7/2026 at 9:28 a.m. with Licensed Vocational Nurse (LVN) 3, LVN 3 stated, Resident1 35 could benefit from an alternative type of call light, that could be activated using his head instead of his hands. During an interview on 4/9/2026 at 9:43 a.m. with Director of Nursing (DON), DON stated that residents who are unable to use their call lights would be unable to seek assistance during an emergency. During a review of the facility's policy and procedure (P&P) titled Answering the Call Light, dated 2001, the P&P indicated residents are to be able to return the demonstration of using the call light and that the call light is to be accessible to the resident when in bed.