STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555503	A. Building B. Wing	12/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Royal Oaks Manor-Bradbury Oaks	1763 Royal Oaks Drive Duarte, CA 91010

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. (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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Based on observation, interview, and record review, the facility failed to provide the following care and services as ordered by Hospice Agency 1's physician:1. An order for Boost (a nutritional supplement drink with essential nutrients to support the resident's nutritional needs) was missed and not included in Resident 1's nutritional supplement orders.2. An order for diclofenac sodium (a drug used in the treatment and management of acute and chronic pain associated with inflammatory conditions) was missed and not included in Resident 1's drug therapy orders. These deficient practices had the potential to result for further resident weight loss and uncontrolled pain.Findings:1. During a review of Resident 1's admission Record (AR), the AR indicated the facility admitted Resident 1 on 10/15/2025, with diagnoses that included displaced intertrochanteric fracture of the left femur (broken thigh bone) and dysphagia (difficulty swallowing). During a review of Resident 1's Minimum Data Set (MDS - a standardized resident assessment tool) dated 10/19/2025, the MDS indicated Resident 1 had moderate cognitive impairment. The MDS indicated Resident 1 required maximal assistance (helper lifts or holds trunk or limbs and provides more than half the effort) with toilet transfers and walking 10 feet) and required moderate assistance (helper lifts, holds or support trunk or limbs, but provides less than half the effort) with lying to sitting on the side of the bed, rolling left and right. During a review of Resident 1's weight on 11/25/2025 at 12:12 PM, Resident 1's weight on 11/20/2025 was 106 pounds (lb, a unit of weight) and on 11/24/2025, the weight was 96 lb. During a review of Resident 1's care plan for The resident has nutritional problem ., the care plan indicated Resident 1 was on hospice (a care focused on comfort and quality of life, not cure, for individuals with a serious or terminal illness) for expected weight loss and overall decline. During a concurrent record review and interview on 11/25/2025 at 4:16 PM, Resident 1's Hospice Agency 1's Current Treatment/Medication/DME List (CTMD) and Resident 1's Order Summary Report (OSR) as of 11/25/2025 was reviewed. The CTMD list included an order for Boost, one (1) can, 237 milliliters once a day for nutrition supplement. Registered Nurse Supervisor (RNS) 1 stated boost was not included in Resident 1's OSR as of 11/25/2025. RN 1 stated boost is a nutritional supplement that would help residents (in general) with weight loss. RN 1 stated RN 1 could not find any documentation that boost was discontinued or placed on hold. RN 1 further stated it needed to be included in Resident 1's active orders. During an interview on 11/26/2025 at 12:12 PM, Licensed Vocational Nurse (LVN) 1 stated there was a new order for boost last night and Resident 1 only had two (2) sips of the boost earlier in the morning. 2. During an observation on 11/26/2025 at 1:23 PM, Certified Nursing Assistant (CNA) 1 and CNA 2 repositioned Resident 1 toward the resident's left side. Resident 1 held the left upper leg with the left hand during repositioning. When asked if Resident 1 was in pain, Resident 1 stated, No. During a concurrent record review and interview on 12/26/2025 at 1:52 PM of Resident 1's Hospice Agency 1's Current Treatment/Medication/DME List (CTMD), there was an order for diclofenac 1% (percent, a portion of a whole) topical gel, one application four times daily for osteoarthritis (a degenerative joint disease resulting a chronic pain and stiffness) of the left hip and lumbar spine. The MDS Nurse stated that holding the left leg could be a sign the Resident 1 was experiencing pain by guarding the area that was in pain. The MDS Nurse stated residents (in general) with dementia may not always be able to verbally report pain. The MDS Nurse further stated the order for diclofenac was missed and that diclofenac could have helped with Resident 1's pain relief. During a review of Resident 1's Medication Administration Record (MAR) for 11/1/2025 to 11/30/2025, the MAR indicated Resident 1 received morphine sulfate (pain medication for the severe pain) on the following dates:11/22/2025 at 11:20 AM for a pain level of 9/10 (9/10 indicates very severe pain. A numeric pain scale is a tool to rate pain using numbers from 0 to 10, where 0 indicates no pain, 10 indicates worst pain imaginable).11/23/2025 at 8:35 AM and 5:48 PM for a pain level of 8/10 and 9/10.11/24/2025 at 8:40 AM, 11:19 AM, and 9:32 PM for a pain level of 9/10, 8/10, and 7/10.11/25/2025 at 7:46 AM for a pain level of 6/10. During a review of the facility's Policy and Procedure (P&P), titled Hospice Program, revised on July 2017, the P&P indicated it is the responsibility of the facility to meet the resident's personal care and nursing needs in coordination with the hospice representative, and ensure that the level of care provided is appropriately based on the individual resident's needs. These responsibilities include administering prescribed therapies.

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** During an interview and record review, the facility failed to ensure call lights were answered immediately for two of three sampled residents (Resident 2 and Resident 3).This deficient practice had the potential to result in residents' unmet needs.Findings: During a review of Resident 2's admission Record (AR), the AR indicated the facility admitted Resident 2 on 11/1/2025, with diagnoses that included fracture of the right humerus (broken bone in the upper arm) and history of falling. During a review of Resident 2's Minimum Data Set (MDS - a standardized resident assessment tool) dated 11/7/2025, the MDS indicated Resident 2 had intact cognition and required maximal assistance (helper lifts or holds trunk or limbs and provides more than half the effort) with sit-to-stand and dependent with rolling left and right and lying-to-sitting. During a review of Resident 3's AR, the AR indicated the facility admitted Resident 3 on 11/14/2025, with diagnoses that included fusion of spine, lumbar region (surgery that connects two or more bones in the spine) and muscle weakness. During an interview on 11/25/2025 at 11:40 AM, Resident 2's Family member (FM 1) stated sometimes staff would take an hour to respond to the call light. FM 1 stated FM 1 would be the one who would assist Resident 2 to the bathroom when staff response was taking too long. During an interview on 11/25/25 at 11:47 AM, Resident 3 stated the resident had been at the facility for two weeks and there were two (2) times it took the facility staff an hour to respond to the call light, it happened once at night and once during the day. Resident 3 stated last night and this morning it was better because facility staff responded within 10-15 minutes. Resident 3 stated the resident would check the clock in front of Resident 3's bed. Resident 3 stated on those two times, no staff came to check what Resident 3 needed. Resident 3 stated the resident would usually call for assistance to the bathroom. During an interview on 11/25/2025 at 1:12 PM, Certified Nursing Assistant (CNA) 3 stated when call lights were pressed, staff needed to go immediately and if not possible, another staff needed to go and check because the call might be an emergency. During an interview on 11/25/2025 at 3:18 PM, Licensed Vocational Nurse (LVN) 2 stated call lights needed to be answered immediately because the call might be an emergency situation, an example would be difficulty breathing. During a review of the facility's Resident Council Meeting minutes indicated the following:On 7/29/2025, residents in attendance stated call lights were not answered timely during the 11:00 PM to 7:00 AM shift.On 9/30/2025, two residents stated call lights were answered, but the needs of the residents were not met. During a review of the facility's Policy and Procedure (P&P), titled Answering the Call Light, revised on September 2022, the P&P indicated, Answer the resident call system immediately. When answering an auditory request for assistance, identify yourself and politely respond to the resident by his/her name (e.g., This is Mrs. [NAME]. Mr. [NAME], how may I help you?). The P&P indicated:a. If the resident needs assistance, indicate the approximate time it will take for you to respond.b. If the resident's request requires another staff member, notify the individual.c. If the resident's request is something you can fulfill, complete the task within five minutes if possible.d. If you are uncertain as to whether or not a request can be fulfilled, or if you cannot fulfill the resident's request, ask the nurse supervisor for assistance.