

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

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555503	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/02/2026
NAME OF PROVIDER OR SUPPLIER Royal Oaks Manor-Bradbury Oaks		STREET ADDRESS, CITY, STATE, ZIP CODE 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 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 inform and provide written information regarding advance directives (a legal document explaining a resident's health care wishes if he or she cannot speak for themselves) for two of five sampled residents (Residents 21 and 22). This failure resulted in Residents 21 and 22 being uninformed of their health care rights and had the potential to result in conflict regarding Residents' 21 and 22's health care decision choices.Findings: a. During a review of Resident 21's admission Record (AR), the AR indicated the facility originally admitted Resident 21 on 12/13/2025 with diagnoses including displaced trimalleolar fracture (a severe ankle break) of the left lower leg, subsequent encounter for open fracture type IIIA, IIIB, or IIIC (a condition where the bone breaks through the skin and there is major soft tissue damage) with routine healing and trigeminal neuralgia (a condition that causes facial pain). During a review of Resident 21's History and Physical (H&P), dated 12/15/2025, the H&P indicated Resident 21 had the capacity to make decisions. During a review of Resident 21's Minimum Data Set (MDS- a resident assessment tool), dated 12/17/2025, the MDS indicated Resident 21's cognitive (the ability to think and process information) skills for daily decision making were intact. During a review of Resident 21's Care Plan (CP) titled The resident's code status/advance directive is full code, initiated 12/31/2025, the CP's interventions indicated advance directive preferences were to be discussed with Resident 21 or Resident 21's responsible party (an individual chosen by the resident to act on behalf of the resident to support the resident in decision-making) on a quarterly basis and as needed. Additionally, the CP's interventions indicated advance directive education would be provided to Resident 21 upon admission and as needed. During a concurrent interview and record review on 12/31/2025 at 2:31 PM with the Social Service Director (SSD), Resident 21's Physician Orders for Life-Sustaining Treatment (POLST, a medical document for seriously ill or frail individuals that translates the person's treatment preferences into actionable medical orders, ensuring the person's wishes for life-sustaining care are followed across different healthcare settings, even when the person cannot communicate), dated 12/13/2025 was reviewed. The SSD stated the POLST did not indicate advance directives were discussed with Resident 21. The SSD stated it was the policy of the facility to give residents (in general) information regarding advance directives by the second or third day of admission. Additionally, the SSD stated the importance of discussing and offering advance directives with residents (in general) was to ensure the residents received life saving measures as requested. (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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 1/2/2026 at 8:43 AM with Resident 21, Resident 21 stated Resident 21 did not have an advance directive and had never received information regarding advance directives from the facility. b. During a review of Resident 22's AR, the AR indicated, Resident 22 was admitted to the facility on [DATE] with multiple diagnoses including unspecified dementia (a progressive state of decline in mental abilities), unspecified severity, without behavioral disturbance, psychotic (relating to or affected with a psychosis - a severe mental condition in which thought, and emotions are so affected that contact is lost with reality) disturbance, mood disturbance, and anxiety (intense, excessive, and persistent worry and fear about everyday situations). During a review of Resident 22's POLST, dated 11/1/2025, the POLST indicated the POLST complemented an AD and was not intended to replace that document (AD). Resident 22's POLST did not indicate any information regarding an AD. During a review of Resident 22's H&P, dated 11/2/2025, the H&P indicated, Resident 22 did not have the capacity to understand and/or sign any form due to dementia. During a review of Resident 22's MDS, dated [DATE], the MDS indicated Resident 22's cognitive skills for daily decision making were moderately impaired (decisions poor, cues/supervision required). The MDS indicated Resident 22 did not have an AD. During a review of Resident 22's undated and unsigned Advance Health Care Directive Acknowledgement Form (AF), the AF indicated, Resident 22 was not given a copy of the Advance Health Care Directive Fact Sheet at the first face-to-face contact or clinic visit. During a review of the Advance Health Care Directive Fact Sheet, revised 2/15/2011, the sheet indicated an advance directive was a legal document that allowed individuals to state their wishes should they become unable to make healthcare decisions. The fact sheet indicated in California, the AD consisted of two parts: (1) appointment of an agent for healthcare and and (2) individual health care instructions. During a review of Resident 22's care plan (CP) titled, [Resident 22's] code status/advance directive is., date initiated 11/29/2025, the CP's interventions indicated to provide advance directive education upon admission and as needed. During a concurrent interview and record review on 12/31/2025 at 2:30 PM with the SSD, Resident 22's medical records (chart) and Social Service History & Initial Assessment (IA), dated 11/2/2025 were reviewed. The SSD stated, the SSD was responsible for obtaining or screening residents (in general) upon admission to obtain information regarding an AD, immediately, or when the SSD conducted my assessment (IA), on the second or third day after admission. The IA indicated, Resident 22 had an AD. The SSD stated, if a resident had an AD, the facility made a copy and filed the copy in the resident's chart. The SSD stated the SSD could not find a copy of Resident 22's AD in Resident 22's chart. The SSD stated, filing a copy of Resident 22's AD in the medical records was important for staff to know what Resident 22's medical wishes were, to avoid confusion among staff, because the POLST could change and the POLST did not replace an AD. During an interview on 1/2/2026 at 9:40 AM with Emergency Contact (EC) 2, EC 2 stated Resident 22 had an AD. EC 2 stated, the facility asked regarding an AD only during the meeting, two weeks [after (continued on next page)]		

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident 22's admission]. During a review of the facility's policy and procedure (P&P), revised 9/2022, the P&P indicated the resident has the right to formulate an advance directive, including the right to accept or refuse medical or surgical treatment. The P&P indicated advance directives are honored in accordance with state law and facility policy. The P&P indicated prior to or upon admission of a resident, the SSD or designee inquires of the resident, his/her family members and/or his or her legal representative, about the existence of any written advance directives. The P&P indicated the resident or representative is provided with written information concerning the right to refuse or accept medical or surgical treatment and to formulate an advance directive if he or she chooses to do so.		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure, three of three sampled residents (Residents 29, 5 and 46), were provided with appropriate activities of daily living (ADLs, basic self-care tasks like bathing, dressing, eating, using the toilet, and moving around). These deficient practices had the potential to result in physical declines due to the lack of assistance with ADLs for Residents 29, 5 and 46. Cross Reference F550 Findings: A. During a review of Resident 29's admission Record (AR), the AR indicated Resident 29 was admitted to the facility on [DATE] with diagnoses that included glaucoma (eye condition that damages the optic nerve which is crucial for good vision, associated with high pressure in the eye), irritable bowel syndrome (a common gastrointestinal disorder characterized by abdominal pain, cramping, bloating, diarrhea, and constipation), and spinal stenosis (pinching of the nerves within the spine causing back pain and weakness in the legs or arms). During a review of Resident 29's History and Physical (H&P), dated 1/7/2025, the H&P indicated Resident 29 was alert and was wheelchair bound. During a review of Resident 29's Bowel and Bladder Program Screener (BBPS), dated 7/21/2025, the BBPS indicated Resident 29 was alert and oriented, was always mentally aware of the need to toilet and needed one-person assistance to get to the bathroom/transfer to toilet/commode/urinal. The BBPS indicated adjusting clothing and wiping and Resident 29 was a candidate for retraining. During a review of the facility's care plan (CP) for ADLs self-care performance deficit related to limitations in functional and physical mobility, revised 8/2/2025, the CP's goal indicated for the resident to maintain current level of function in ability to participate in self-care tasks. The CP's intervention indicated Resident 29 was totally dependent on 1 staff for toilet use and to encourage Resident 29 to participate to the fullest extent possible with each interaction. During a review of a Minimum Data Set (MDS, a resident assessment and care-screening tool), dated 10/21/2025, the MDS indicated Resident 29 had clear speech, had the ability to understand, and be understood by others. The MDS indicated Resident 29 was dependent (helper does all the effort) with toileting hygiene (ability to maintain hygiene, adjust clothes before and after voiding or having a bowel movement). During an observation and concurrent interview with Resident 29, on 12/31/2025 at 11:30 AM, Resident 29 was observed sitting on a wheelchair and was assisted by the Activities Director (AD) to the conference room. Resident 29 stated a few times last week (no specific date recall), Resident 29 asked Certified Nursing Assistant (CNA) 2 for assistance to the toilet. Resident 29 stated I have the urge to go to the bathroom sometimes, and I want to sit on the toilet and do what I feel I need to do. When I ask [CNA 2] to take me to the restroom, CNA 2 tells me, No you don't have to go, and does not take me and does not give me a reason why. Resident 29 stated Resident 29 preferred to sit on the toilet. During an interview with the AD, on 12/31/2025 at 12:38 PM, the AD stated Resident 29 was alert with periods of confusion. The AD stated on 12/30/2025, Resident 29 informed the AD CNA 2 did not take Resident 29 to the toilet when Resident 29 asked. (continued on next page)		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 12/31/2025 at 1:34 PM, with Licensed Vocational Nurse 2 (LVN 2), LVN 2 stated Resident 29 had urges for bowel movements. LVN 2 stated Resident 29 preferred to sit on the commode (portable toilet) when Resident 29 needed to use the restroom. LVN 2 stated ADLs were important because [encouraging] residents physically and psychologically to do things on their own was one of the most important things a nurse could do. During an interview, on 12/31/2025 at 1:42 pm, with CNA 7, CNA 7 stated Resident 29 preferred to be assisted to the commode when Resident 29 needed to use the restroom. CNA 7 stated if a resident requested assistance to the restroom, [staff] had to take the resident and if unable to take the resident, [staff] had to ask for help from other staff. During an interview with the Director of Nursing (DON), on 1/2/2026 at 10:35 AM, the DON stated examples of ADL's included bathing, personal grooming, toileting (assisting to the commode) and [ADLs] should be addressed as soon as possible. The DON stated staff should assist residents when residents asked [for assistance] because, if ignored, it could lead to incontinence (lack of bladder control) and loss of bowel control. B. During a review of Resident 5's AR, the AR indicated, Resident 5 was originally admitted to the facility on [DATE] and readmitted on [DATE] with multiple diagnoses including major depressive disorder (a mental health condition characterized by persistent feelings of sadness, loss of interest, and other symptoms that significantly interfere with daily life), recurrent, unspecified, and unspecified macular degeneration (an eye disease that affects central vision where people can't see things directly in front of them). During a review of Resident 5's H&P, dated 7/2/2025, the H&P indicated Resident 5 was alert, oriented to person, place, and time. The H&P indicated Resident 5 had normal cognition (the mental action or process of acquiring knowledge and understanding). During a review of Resident 5's MDS, dated [DATE], the MDS indicated Resident 5 had impaired (sees large print, but not regular print in newspaper/books) vision and Resident 5's cognitive skills (ability to think and process information) for daily decision making were moderately impaired (decisions poor, cues/supervision required). The MDS indicated, Resident 5 was dependent (helper does all of the effort) and required supervision or touching assistance (helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity) for ADLs and was on hospice (compassionate care for people who are near the end of life provided at the person's home or within a health care facility) care. During a review of Resident 5's CP, titled, The resident has an ADL self-care performance deficit., date initiated 7/17/2025, the CP's interventions indicated Resident 5 required (max) assist by (1) staff with personal hygiene and oral care. C. During a review of Resident 46's AR, the AR indicated, Resident 46 was originally admitted to the facility on [DATE] and readmitted on [DATE] with multiple diagnoses including cerebral ischemia (a serious medical condition where the brain doesn't get enough blood flow) and end stage renal disease (ESRD &ndash; irreversible kidney failure). During a review of Resident 46's CP, titled, [Resident 46] has an ADL self-care performance deficit., date initiated 10/21/2024, the CP's interventions indicated to provide assistance with the following self-care and mobility usual performance such as oral hygiene-substantial/max assist and personal (continued on next page)		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	hygiene-dependent. During a review of Resident 46's H&P, dated 1/15/2025, the H&P indicated, Resident 46 was AOx3 (alert and oriented to person, place, and time). During a review of Resident 46's MDS, dated [DATE], the MDS indicated Resident 46's cognitive skills for daily decision making were moderately impaired. The MDS indicated Resident 46 was dependent and required substantial/maximal assistance (helper does more than half the effort) for ADLs. During a concurrent observation and interview on 12/30/2025 at 10:05 AM with CNA 3, Resident 5 was lying in bed, awake, and Resident 5's lips were dry, flaky, and were peeling. Resident 5 had drool with food debris on Resident 5's right side of the mouth. Resident 5's deformed fingers had brownish black colored substance (dirt like appearance) under Resident 5's fingernails. CNA 3 stated Resident 5's chapped lips could bleed, and stated Resident 5 was fed by facility staff. CNA 3 stated CNA 3 would give Resident 5 a bath. During an interview on 12/30/2025 at 10:58 AM, with CNA 3, CNA 3 stated Resident 5's family did not want hospice to take care of Resident 5 [and perform care like] bathing and wanted the facility to provide the care, the shower and everything. During a concurrent observation and interview on 12/31/2025 at 8:33 AM with Resident 46, Resident 46 was lying in bed, awake, and Resident 46's head was facing right. Resident 46 had food debris drool on the right side of Resident 46's mouth and whitish creamy colored discharge from Resident 46's inner corner of the left eye. Resident 46 stated, staff helped feed Resident 46, here and there. During an interview on 12/31/2025 at 11:59 AM with CNA 5, CNA 5 stated after staff collected resident's (in general) food trays, staff should check if residents were dirty after eating, no matter what, I always do check the resident after they eat, if they are dirty. During an interview on 1/2/2026 at 8:08 AM with LVN 5, LVN 5 stated, ADLs included providing cleanliness, oral care, and grooming. LVN 5 stated, staff should do oral care right after residents finished eating or when staff collected the meal trays. LVN 5 stated, Resident 5's chapped lips could crack, open, and cause the skin to open and bleed. LVN 5 stated, providing oral care and keeping fingernails clean were a part of grooming and were important for resident's well-being and for dignity. During a review of the facility's policy and procedure (P&P) titled, Dignity, revised date February 2021, the P&P indicated, each resident should be cared for in a manner that promoted and enhanced his or her sense of well-being, level of satisfaction with life, and feelings of self-worth and self-esteem. During a review of the facility's P&P titled Activities of Daily Living (ADL), Supporting, revised 4/2025, the P&P's statement indicated residents are provided with care, treatment, and services as appropriate to maintain or improve their ability to carry out ADLs. The P&P indicated residents who are unable to carry out ADLs independently receive the services necessary to maintain good nutrition, grooming, and personal and oral hygiene. The P&P indicated appropriate care and services are provided for residents who are unable to carry out ADL's independently, with the consent of the resident and in accordance with the plan of care, including appropriate support and assistance with: elimination (toileting) and hygiene (bathing, dressing, grooming, and oral care).		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to: 1.Destroy discontinued controlled medications (DCM - prescription drugs that have a potential for dependence and have been discontinued) deposited into the MedSafe (MS, refers to a specialized medication disposal receptacle used to manage unused, expired, or unwanted medications, designed to prevent misuse of medications) were still whole, identifiable, retrievable, and left with original packaging (blister packs [individually sealed compartments of medications, one dose per compartment]). 2. Verify and ensure accurate account of DCMs were deposited into the MS when the Consultant Pharmacist (CP) failed to verify accuracy of the Controlled Drug Record (CDR, a detailed log to track every movement of a tightly regulated drug, from the acquisition to final use or disposal, documenting the activity to ensure accountability and to prevent diversion) and the DCMs. 3. Ensure the box that contained DCMs, after removing the DCMs from the MS, was stored in a secured double locked area from [DATE] to [DATE] as indicated in the facility's policy titled Disposal of Medications. These deficient practices had the potential to delay inventory processes and compromise the accurate identification and disposition (safe and proper disposal of unused, unwanted, expired, or discontinued controlled drugs) of controlled medications, creating a possible risk for DCM diversion (illegal redirection of prescription medications like controlled drugs).Findings:1.During an observation and concurrent interview with Licensed Vocational Nurse 2 (LVN 2), inside the facility's medication room, on [DATE] at 10:24 AM, there was a blue receptacle (a container that holds something) that had three separate locks. LVN 2 stated this (pointed to the receptacle) was called a MS where all discontinued medications were deposited, including DCMs. LVN 2 stated DCMs were deposited by the Director of Nursing (DON) into the MS in its original medication packaging.During an interview, on [DATE] at 10:47 AM, with the DON, the DON stated the facility's protocol for DCMs was for a Licensed Nurse (LN) and DON to reconcile the number of DCMs [together] by verifying and signing the Controlled Drug Record (CDR, a detailed log to track every movement of a tightly regulated drug, from the acquisition to final use or disposal, documenting the activity to ensure accountability and to prevent diversion). The DON stated, after reconciling the DCMs, the DON unlocked and deposited the DCMs into the MS in the original packaging. The DON stated when the MS box was full, together, the CP and the DON opened the MS, removed the inner plastic liner bag from the MS containing all DCMs, secured the plastic liner bag with a zip tie, and placed the sealed liner inside a hard cardboard box. The DON stated the box was sealed and was ready for pick up [by a contracted waste company]. The DON stated the box holding the DCMs was If [the hard cardboard box was] tampered with, the medications could be identifiable because they were in [the original] packaging.During a telephone interview with the CP, on [DATE] at 11:25 AM, the CP stated the process of dissolution for DCMs was for the DON and a LN to deposit the DCMs into the MS whole and in their original packaging. The CP stated the CP only reviewed the CDRs and did not physically check/verify the contents in the MS. The CP stated when the MS was full, the DON and the CP removed and sealed the inner plastic liner holding all DCMs and placed the liner in a cardboard box, sealed the box, and was ready for shipment. The CP stated once the DCMs left the facility, the CP did not know or could not guarantee, it [the box with DCMs] was tampered with. The CP stated the CP did not have control over the disposition of DCMs or what [DCMs] were being disposed into the MS. The CP stated the CP did not physically inspect the contents of DCM inside the MS because it was against protocol. The CP stated, in the past, the CP removed the DCMs from the original packaging and wasted (destroy/dissolve/make unidentifiable) the DCMs at the facility and in the presence of the DON. The CP stated the CP liked having more control over the destruction process of DCMs.During a review of the facility's policy and procedure (P&P) titled Disposal of Medications, dated 11/2017, the P&P indicated controlled substances shall be destroyed (continued on next page)		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	by a registered nurse (RN) employed by the care center and a consultant pharmacist or a pharmacist from the contracted pharmacy and transferred to a container marked as for Incineration Only for release to a pharmaceutical waster contractor. The P&P indicated DO NOT USE A CONTAINER USED FOR SHAPRS OR CONTAMINATED WASTE. During a review of the facility P&P titled Collection of Receptacle for Disposal of Medications, dated 1/2023, the P&P indicated once a substance has been deposited into a collection receptacle, the substance shall not be counted, sorted, inventoried, or otherwise individually handled. The P&P indicated if a substance needed to be removed from the receptacle prior to sealing the liner, it must be done by law enforcement. 2. During an interview and concurrent record review of 27 CDRs, on [DATE] at 10:47 AM, with the DON, the DON stated the facility's protocol was for the DON and a LN to verify and sign the CDR to ensure the number of DCMs were the same as the number of DCMs deposited into the MS. The DON stated during the CPs monthly visits, the CP reviewed and signed the CDRs checking the controlled medication counts but the CP did not verify the deposited DCMs inside the MS. The DON stated 17 of the 27 reviewed CDRs did not have the CP's signature and were not reviewed by the CP. The DON stated the DON and the CP only checked the CDR but did not verify the accuracy of the CDR or the DCMs. The DON stated ensuring accuracy was important to prevent the risk of diversion. During a telephone interview with the CP, on [DATE] at 11:32 AM, the CP stated the CP monitored the CDR by signing the margin but did not physically check the contents of the MS to verify accuracy [of the CDR]. [Following this system,] the CP stated the CP could not ensure the DCMs inside the MS were the same DCMs listed on the CDR. The CP stated the CP took the word of the nurses when determining the accuracy of the DCM count. The CP stated the CP had no way of looking in the MS and confirm. During a review of the facility's P&P titled Disposal of Medications, dated 11/2017, the P&P indicated a controlled medication disposition log, or equivalent form, shall be used for documentation. The consultant pharmacist or a pharmacist from the contracted pharmacy will verify accuracy and record shall be retained as per federal privacy and state regulations. 3. During a record review of the Multipurpose Drug Disposition Record (MDDR), the MDDR indicated on [DATE], a United Parcel Service (UPS, a global shipping company) pick up was scheduled between the hours of 9 AM to 5 PM. The MDDR indicated Pharmacy visit new liner # . and Removal/sealed tracking # . was witnessed by the CP and the DON on [DATE]. The MDDR indicated a tracking number on [DATE]. During a review of an email from the DON, dated [DATE], the email's subject indicated Waste [MS] pick-up the email indicated no one had picked up the cardboard box containing DCMs. During a review of a document from UPS titled Schedule a Pickup, the document's pickup date [DATE], the document indicated a pickup request was completed. During an observation on [DATE] at 10:24 AM, [DATE] at 8:17 AM, and on [DATE] at 9:32 AM, the door to the DON's empty office was wide open. During an interview with the DON, on [DATE] at 10:47 AM, the DON stated the facility's protocol for DCMs was for the DON and a LN to witness, and sign the CDR, and deposit all DCMs inside the MS in its original packaging. The DON stated that when the MS was full, the CP and the DON opened the MS together, removed, replaced, and sealed the inner plastic liner containing all DCMs and zip tie the liner. The DON stated, the DON would then place the inner liner inside a cardboard box, sealed the box, and the box was picked up by a medication waste company. During an interview with the DON, on [DATE] at 12:10 PM, the DON stated on [DATE], the CP and the DON collected the MS Waste (MSW - including DCMs) and sealed the cardboard box to make ready for disposal pick-up. The DON stated the MSW was not picked up until [DATE]. The DON stated the cardboard box containing MSW was stored in the DON's office, next to the DON's desk. During an interview with the DON on [DATE] at 10:35 AM, the DON stated on [DATE] to [DATE], multiple attempts were made for MSW pick up. The MSW box was stored in the DON office, next to the DON's desk from [DATE] to [DATE]. The DON stated the DON could not put the MSW back into the MS because a new box and liner were already in place and the DON did not have a key to open the MS. The DON stated the DON's office did not have a double lock. The DON stated it was important for DCMs to be securely stored in a double lock area for safe (continued on next page)		

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

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Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555503	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/02/2026
NAME OF PROVIDER OR SUPPLIER Royal Oaks Manor-Bradbury Oaks		STREET ADDRESS, CITY, STATE, ZIP CODE 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.			
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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	keeping and avoid tampering [diversion of DCMs].During a review of the facility's P&P titled Disposal of Medications, dated 11/2017, the P&P indicated controlled substances are subject to special handling, storage, disposal, and record keeping in the nursing care center. The P&P indicated controlled substances . remaining in the nursing care center after the order has been discontinued are retained in the nursing care center in a securely double locked area with restricted access until destroyed.During a review of the facility's P&P titled Collection of Receptacles for Disposal of Medications, dated 1/2023, the P&P indicated, under Receptacle Liners - Responsibility of Pharmacy and Facility/Community, the inner liner shall be tamper evident and tear resistant. The P&P indicated upon removal from the permanent outer container, sealed inner liners may be stored at the long-term care facility for up to three business days in a securely locked, substantially constructed cabinet or a securely locked room with controlled access until [picked up by the] UPS carrier .		

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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 implement infection (the invasion and growth of germs in the body) prevention and control practices by failing to ensure: a. Masks were readily available upon entrance to the facility. b. Gloves were readily available outside of two of four sampled resident (Resident 3 and Resident 46) rooms, who were on Enhanced Barrier Precautions (EBP - infection control measures, primarily for nursing homes, using gowns and gloves during direct, high-contact care for residents with multidrug-resistant organisms [MDROs] or at high risk). These deficient practices had the potential to result in cross contamination (the process by which microorganisms are unintentionally transferred from one area/object to another with a harmful effect) and/or the development and transmission of disease (an illness or sickness) and infections for Resident 3 and Resident 46. Findings: a. During an observation on 12/30/2025 at 8:40 AM, a large three feet by three feet (3 ft x 3 ft, unit of length) freestanding sign indicating No Mask! No Entry! No Exemption! was outside in front of the facility's entrance door. There were no masks available upon entrance to the facility. Signage posted in the hallway indicated, To keep each other safe and healthy, this facility is asking everyone to please wear a mask. Masks can help prevent the spread of respiratory infections. b. During a review of Resident 3's admission Record (AR), the AR indicated, Resident 3 was originally admitted to the facility on [DATE] and readmitted on [DATE] with multiple diagnoses including personal history of urinary (tract) infections (UTI - an infection in the bladder/urinary tract), Extended Spectrum Beta Lactamase (ESBL - refers to specific bacteria, super-germs) resistance, and sepsis (a life-threatening blood infection), unspecified organism. During a review of Resident 3's History and Physical (H&P), dated 8/12/2025, the H&P indicated, Resident 3 did not have the capacity to understand and/or sign any forms. During a review of Resident 3's Minimum Data Set (MDS - a resident assessment tool), dated 10/14/2025, the MDS indicated Resident 3's cognitive skills (ability to think and process information) for daily decision making were severely impaired. The MDS indicated, Resident 3 was dependent (helper does all of the effort) for activities of daily living (ADL - routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves). During a review of Resident 3's Order Summary Report (OSR), active orders as of 1/2/2026, the OSR indicated an order dated 8/13/2025 for EBP every shift for wound, gastrostomy tube (GT - a feeding tube inserted through the abdomen directly into the stomach), history of ESBL and Providencia Stuartii (a type of bacteria). During a review of Resident 46's AR, the AR indicated, Resident 46 was originally admitted to the facility on [DATE] and readmitted on [DATE] with multiple diagnoses including cerebral ischemia (a serious medical condition where the brain doesn't get enough blood flow) and end stage renal disease (ESRD - irreversible kidney failure), and dependence on renal dialysis (a treatment that cleanses the blood of wastes and extra fluids artificially through a machine when the kidney[s] have failed). During a review of Resident 46's H&P, dated 1/15/2025, the H&P indicated, Resident 46 was AOx3 (alert and oriented to person, place, and time). During a review of Resident 46's MDS, dated [DATE], the MDS indicated Resident 46's cognitive skills for daily decision making were moderately impaired. The MDS indicated Resident 46 was dependent and required substantial/maximal assistance (helper does more than half the effort) for ADLs. During a review of Resident 46's OSR, active orders as of 1/2/2026, the OSR indicated an order, dated 6/19/2025 for EBP every shift d/t (due to) on hemodialysis. During a concurrent observation and interview on 12/30/2025 at 11:12 AM with Certified Nurse Assistant (CNA) 7, Resident 3's room had an EBP signage on the door and a black color trimmed 4-drawer PPE (personal protective equipment - clothing and equipment that is worn or used to provide protection against hazardous substances and/or environments) cart was outside of Resident 3's room. The EBP signage indicated, providers and staff must wear gloves and a gown for high-contact resident care activities. There were no gloves in/on the PPE cart. CNA 7 stated, there was usually a box of gloves (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	[in/on the PPE cart] because Resident 3 was on EBP. During a concurrent observation and interview on 12/30/2025 at 4:26 PM with CNA 4, Resident 46's room had an EBP signage on the door and a black color trimmed 4-drawer PPE cart outside of Resident 46's room. There were no gloves in/on the PPE cart. CNA 4 stated, staff followed whatever was indicated on the EBP signage such as wearing gowns and gloves. CNA 4 stated staff should ensure there were PPE supplies prior to entering Resident 46's room in order to follow EBP and as indicated on the signage. During an interview on 1/2/2026 at 1:42 PM with the Infection Preventionist (IP), the IP stated, masking was required since we're in the respiratory virus [a germ that attacks your nose, throat, and lungs] season. The IP stated, ensuring a supply of masks was readily available was important to enforce masking and to remind staff and visitors to wear masks, that's why we have that super big sign outside. The IP stated, ensuring a supply of PPE was readily available including gloves was important for staff to be compliant with EBP and for infection control. During a review of the undated Centers for Disease Control and Prevention's (CDC - the national public health agency who provides accurate data, health guidance, and preventive measures) EBP signage poster, the facility signage poster indicated, providers and staff must also wear gloves and gown for high-contact resident care activities: dressing, bathing, showering, transferring, changing linens, providing hygiene, changing [adult] briefs, assisting with toileting, and wound care. During a review of the CDC's Frequently Asked Questions (FAQ's) Absent Enhanced Barrier Precautions in Nursing Home, dated 6/28/2024, the FAQ's indicated, Enhanced Barrier Precautions are an infection control intervention designed to reduce transmission of multidrug-resistant organisms (MDROs) in nursing homes. Enhanced Barrier Precautions involve gown and glove use during high-contact resident care activities for residents known to be colonized or infected with a MDRO as well as those at increased risk of MDRO acquisition (e.g., residents with wounds or indwelling medical devices). https://www.cdc.gov/long-term-care-facilities/hcp/prevent-mdro/faqs.html During a review of CDC's guidelines titled Preventing Transmission of Viral Respiratory Pathogens in Healthcare Settings dated 5/21/2025, the guidelines indicated, healthcare facilities should ensure the availability of materials for adhering to respiratory hygiene/cough etiquette at facility entrances, triage areas, and waiting areas for patients and visitors. The guidelines indicated during periods of higher levels of community respiratory virus transmission, facilities should consider having everyone mask upon entry to the facility to ensure better adherence to respiratory hygiene and cough etiquette for those who might be infectious. Examples reflecting higher levels of community respiratory virus transmission could include months during the typical respiratory virus season (e.g., October-April).		

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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 interview and record review, the facility failed to treat one of one sampled resident (Resident 29) with respect and dignity when Certified Nurse Assistant 2 (CNA 2) failed to assist Resident 29 to the restroom making Resident 29 feel bad, like a fireman dummy, and a child. This deficient practice had the potential to affect Resident 29's psychosocial well-being. Cross Reference F677 Findings: During a review of an admission Record (AR), the AR indicated Resident 29 was admitted to the facility on [DATE] with diagnoses that included glaucoma (eye condition that damages the optic nerve which is crucial for good vision, associated with high pressure in the eye), irritable bowel syndrome (a common gastrointestinal disorder characterized by abdominal pain, cramping, bloating, diarrhea, and constipation), and spinal stenosis (pinching of the nerves within the spine causing back pain and weakness in the legs or arms). During a review of Resident 29's History and Physical (H&P), dated 1/7/2025, the H&P indicated Resident 29 was alert and was wheelchair bound. During a review of Resident 29's Bowel and Bladder Program Screener (BBPS), dated 7/21/2025, the BBPS indicated Resident 29 was alert and oriented, was always mentally aware of the need to toilet and needed one-person assistance to get to the bathroom/transfer to toilet/commode/urinal. During a review of the facility's care plan (CP) titled Risk for constipation [related to] low mobility, initiated 8/2/2025, the CP's goal indicated Resident 29 would pass soft, formed stools at the preferred frequency. During a review of the facility's CP for activities of daily living self-care performance deficit related to limitations, revised 8/2/2025, the CP's intervention indicated Resident 29 was totally dependent on 1 staff for toilet use and to encourage Resident 29 to participate to the fullest extent possible with each interaction. During a review of a Minimum Data Set (MDS, a resident assessment and care-screening tool), dated 10/21/2025, the MDS indicated Resident 29 had clear speech, had the ability to understand, and be understood by others. The MDS indicated Resident 29 was dependent (helper does all the effort) with toileting hygiene (ability to maintain hygiene, adjust clothes before and after voiding or having a bowel movement). During an observation and concurrent interview with Resident 29, on 12/31/2025 at 11:30 AM, Resident 29 was observed sitting on a wheelchair and was assisted by the Activities Director (AD) to the conference room. Resident 29 stated a few times last week (no specific date recall), Resident 29 asked CNA 2 for assistance to the toilet. Resident 29 stated I have the urge to go to the bathroom sometimes, and I want to sit on the toilet and do what I feel I need to do. When I ask [CNA 2] to take me to the restroom, CNA 2 tells me 'no you don't have to go' and does not take me and does not give me a reason why. Resident 29 stated Resident 29 had control over his body and preferred to sit on the toilet. Resident 29 stated CNA 2 made Resident 29 feel bad like a fireman dummy, one that gets thrown around and gets attention when CNA 2 chooses or like a child asking for permission to go to the restroom, hoping they [CNA 2] will say yes. During an interview with the AD, on 12/31/2025 at 12:38 PM, the AD stated Resident 29 was alert with periods of confusion. The AD stated on 12/30/2025, Resident 29 informed the AD CNA 2 did not take Resident 29 to the toilet when Resident 29 asked. During an interview on 12/31/2025 at 1:34 PM, with Licensed Vocational Nurse 2 (LVN 2), LVN 2 stated Resident 29 had urges for bowel movements. LVN 2 stated Resident 29 preferred to sit on the commode when Resident 29 needed to use the restroom as a form of dignity. LVN 2 stated activities of daily living were important because [encouraging] residents physically and psychologically to do things on their own was one of the most important things a nurse could do. During an interview, on 12/31/2025 at 1:42 pm, with CNA 7, CNA 7 stated Resident 29 preferred to be assisted to the commode when Resident 29 needed to use the restroom. CNA 7 stated if a resident requested assistance to the restroom, [staff] had to take the resident and if unable to take the resident, [staff] had to ask for help from other staff. During an interview with the Director of Nursing (DON), on 1/2/2026 at 10:35 AM, the DON stated when a resident had the urge to have a (continued on next page)		

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	bowel movement it was personal and this needed to be taken seriously because [not attending to this need] effected the resident's psychosocial [wellbeing] and dignity. During a review of the facility's policy and procedure (P&P) titled Dignity, revised 2/2021, the P&P's statement 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, and feelings of self-worth and self - esteem. The P&P indicated residents are treated with dignity and respect at all times. The P&P indicated demining practices and standards of care that compromised dignity are prohibited. The P&P indicated staff are expected to promote dignity and assist residents: for example: promptly responding to a resident's request for toileting assistance.		

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. Based on interview and record review, the facility failed to complete a Preadmission Screening and Resident Review Level 2 screening (PASARR II-a required federal assessment that ensures individuals with a mental disorder or intellectual disability are placed in appropriate facilities) for one of one sampled resident (Resident 2) when the facility did not reply to the recommendations by the California Department of Health Care Services (DHCS-a state agency that oversees the provision of health care and mental health services) for an attempted evaluation of PASARR level 2 as indicated by the facility's Policy and Procedure (P&P) titled, admission Criteria.This failure resulted in Resident 2 not receiving the PASARR level 2 screening for serious mental illness (SMI-a diagnosable mental, behavioral, or emotional disorder that significantly impairs a person's ability to function in major life activities) and had the potential for Resident 2 to not receive specialized services (the services specified by the State that exceed the services ordinarily provided by the nursing facility) for SMI.Findings:During a review of Resident 2's admission Record (AR), the AR indicated the facility originally admitted Resident 2 on 5/10/2024 with diagnoses including orthostatic hypotension (a sudden drop in blood pressure when standing) and unspecified dementia (the loss of the ability to think, remember, and reason that affect daily life and activities).During a review of Resident 2's History and Physical (H&P), dated 7/4/2025, the H&P indicated Resident 2 was alert and oriented to name only.During a review of Resident 2's PASARR Level 1 Screening (the PASARR prescreening process which determines if a resident has a mental disorder, intellectual disability or related condition), dated 12/19/2025, the PASRR Level 1 Screening indicated Resident 2 had an SMI.During a review of Resident 2's Minimum Data Set (MDS- a resident assessment tool), dated 12/22/2025, the MDS indicated Resident 2's cognitive (the ability to think and process information) skills for daily decision making were severely impaired (resident never or rarely makes decisions). During a concurrent interview and record review on 12/31/2025 at 1:24 PM with the Director of Nursing (DON), Resident 2's untitled DHCS notification letter, dated 12/24/2025, was reviewed. The DHCS notification letter's subject indicated Notice of attempted evaluation. The DHCS notification letter indicated, In the event of a positive SMI Level 1 Screening [PASSAR Level 1 Screening], a SMI Level 2 Mental health Evaluation [PASSAR Level 2 Screening] is required to determine if the individual can benefit from specialized services. However, a SMI Level 2 Mental Health Evaluation [PASSAR Level 2 Screening] was not scheduled for the following reason: Facility staff were unresponsive to two or more separate attempts of communication within 48 hours of the Level 1 Screening. The DON stated the facility did not respond to Resident 2's DHCS notification letter. The DON stated the facility should have responded to Resident 2's DHCS notification letter to verify Resident 2 was receiving proper care and services.During a review of the facility's P&P titled, admission Criteria, revised March 2019, the P&P's policy statement indicated the facility admitted on ly residents who's medical and nursing care needs could be met. The P&P's policy interpretation and implementation indicated all new admissions and readmissions were screened for mental disorders (MD), intellectual disabilities (ID) or related disorders (RD). Additionally, the P&P indicated if the level I screening indicated the individual may have met the criteria for a MD, ID, or RD, he or she was referred to the state PASARR representative for the Level II screening process. The P&P further indicated that upon completion of the Level II evaluation, the state PASARR representative would determine if the individual had a physical or mental condition, what specialized or rehabilitative services he or she needed, and whether placement in the facility was appropriate.		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **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 5) eye wash irrigating solution, and a non-legend drug (medication that can be purchased over-the-counter [OTC] without a prescription) was not stored inside Resident 5's room. This deficient practice had the potential to result in non-licensed staff or family using the eye irrigating solution to treat Resident 5 and the potential to compromise Resident 5's physical well-being. Findings: During a review of Resident 5's admission Record (AR), the AR indicated, Resident 5 was originally admitted to the facility on [DATE] and readmitted on [DATE] with multiple diagnoses including major depressive disorder (a mental health condition characterized by persistent feelings of sadness, loss of interest, and other symptoms that significantly interfere with daily life), recurrent, unspecified, and unspecified macular degeneration (an eye disease that affects central vision where people can't see things directly in front of them). During a review of Resident 5's History & Physical H&P, dated 7/2/2025, the H&P indicated Resident 5 was alert, oriented to person, place, and time. The H&P indicated Resident 5 had normal cognition (the mental action or process of acquiring knowledge and understanding). During a review of Resident 5's Minimum Data Set (MDS - a resident assessment tool), dated 10/29/2025, the MDS indicated Resident 5 had impaired (sees large print, but not regular print in newspaper/books) vision and Resident 5's cognitive skills (ability to think and process information) for daily decision making were moderately impaired (decisions poor, cues/supervision required). The MDS indicated, Resident 5 was dependent (helper does all of the effort) and required supervision or touching assistance (helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity) for ADLs and was on hospice (compassionate care for people who are near the end of life provided at the person's home or within a health care facility) care. During a review of Resident 5's Order Summary Report (OSR), active orders as of 1/2/2026, the OSR did not indicate an order for Resident 5's eye wash irrigating solution to be used or stored inside Resident 5's room. During an observation on 12/30/2025 at 9:37 AM, there was a 4 Fl oz (fluid ounce - a unit of volume for liquids) bottle of Walgreens Soothing Eye Wash Eye Irrigating Solution on the sink counter of Resident 5's restroom. The solution's container box was marked with Resident 5's name. During an interview on 1/2/2026 at 8:08 AM with Licensed Vocational Nurse (LVN) 5, LVN 5 stated, Resident 5's eye wash irrigating solution was considered an OTC medication and was for [eye] treatment. LVN 5 stated, not leaving the eye wash irrigating solution inside Resident 5's room was important because the eye irrigating solution was considered a medication and only licensed staff [could administer this medication] to Resident 5 and staff needed to check Resident 5's room for safety to ensure it doesn't get into the wrong hands, should be properly handled by the proper staff. LVN stated, Resident 5's eye irrigating solution did not come from the facility's [pharmacy]. During a review of the facility's undated policy and procedure (P&P) titled, House Supplied (Floor Stock) Medications, the P&P indicated the nursing care center may maintain a supply of commonly used OTC medications considered as floor stock or house medications as allowed by state regulations. The P&P indicated floor stock items were not to be administered without a current order from the resident's prescriber. During a review of the facility's P&P titled, Medications Brought to the Facility by the Resident/Family, revised 4/2007, the P&P indicated, the facility should ordinarily not permit residents and families to bring medication into the facility. The P&P indicated, if a medication was not otherwise and/or it was determined to be essential to the resident's life, health, safety, or well-being to be able to take a medication brought in from outside, the director of nursing services and nursing staff, with support of the attending physician and consultant pharmacist, should check to ensure that the medications have been ordered by the resident's attending physician, and documented on the physician's order sheet. During a review of the facility's P&P titled, Self-Administration of Medications, revised 2/2021, the P&P indicated, any (continued on next page)		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	medications found at the bedside that are not authorized for self-administration were turned over to the nurse in charge for return to the family or responsible party.		

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. Based on interview and record review the facility failed to ensure a medication regimen review (MRR-a thorough evaluation of a resident's medications) was completed for one of five sampled residents (Resident 11) when Resident 11 did not have documented evidence of a completed MRR during the months of November and December 2025. This failure had the potential to result in Resident 11 experiencing adverse consequences (impairment or decline in an individual's mental, physical, functional, or psychosocial status [the emotional and social requirements that individuals must have to feel safe, supported, and capable of functioning well in their environment]) from medications. Based on interview and record review the facility failed to ensure a medication regimen review (MRR-a thorough evaluation of a resident's medications) was completed for one of five sampled residents (Resident 11) when Resident 11 did not have documented evidence of a completed MRR during the months of November and December 2025. This failure had the potential to result in Resident 11 experiencing adverse consequences (impairment or decline in an individual's mental, physical, functional, or psychosocial status [the emotional and social requirements that individuals must have to feel safe, supported, and capable of functioning well in their environment]) from medications. Findings:During a review of Resident 11's admission Record (AR), the AR indicated the facility originally admitted Resident 11 on 6/17/2024 with diagnoses including major depressive disorder (mental health condition where a person experiences a persistent low mood, loss of interest in activities and other symptoms that significantly impact daily life) and unspecified dementia (the loss of the ability to think, remember, and reason that affect daily life and activities).During a review of Resident 11's History and Physical (H&P), dated 7/20/2025, the H&P indicated Resident 11 had the capacity to understand and sign any form.During a review of Resident 11's Minimum Data Set (MDS- a resident assessment tool), dated 9/17/2025, the MDS indicated Resident 11's cognitive (the ability to think and process information) skills for daily decision making were moderately impaired (resident makes poor decisions requiring cues or supervision).During a review of Resident 11's Care Plan (CP) titled The resident [Resident 11] has Dx. [diagnosis] of depression-on antidepressant medication (Lexapro), initiated 10/7/2024, revised 10/24/2025, the CP's interventions indicated a pharmacy review would be done monthly or per protocol (a formal set of rules or procedures) for Resident 11.During a concurrent interview and record review on 1/2/2026 at 9:13 AM with the Director of Nursing (DON), the facility's 2025 MRR binder was reviewed. The DON stated Resident 11's MRR for November and December 2025 were not done. The DON stated the importance of completing and documenting monthly MRRs was to ensure Resident 11's safety and to ensure any recommendations regarding Resident 11's medications were addressed. During a review of the facility's Policy and Procedure (P&P) titled, Drug Regimen Review, effective 11/28/2016, revised 8/3/2023, the P&P's policy indicated the health center's drug regimen review program would include a monthly drug regimen review that included review of all medication orders and the documented medication administration process. The P&P's procedure indicated the DON was responsible for scheduling and maintaining monthly drug regimen reviews for quality improvement purposes. Additionally, the P&P's procedure indicated a record of the consultant pharmacist's observations and recommendations would be made available to the DON or designee within 48 hours of MRR completion.		