STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055341	A. Building B. Wing	08/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Gem Transitional	716 South Fair Oaks Ave Pasadena, CA 91105

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 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. 47362 Based on observation, interview, and record review the facility failed to ensure one (1) of five (5) sampled residents (Residents 1) was provided privacy during perineal care (the practice of washing the genital and rectal areas of the body). This deficient practice had the potential to result in Resident 1 ' s feelings of decreased self-esteem and self-worth. Findings: Druing a review of Resident 1 ' s admission record indicated the facility admitted Resident 1 on 7/5/2024 with diagnosis which include dementia (loss of memory, language, problem-solving and other thinking abilities that are severe enough to interfere with daily life), depression (mood disorder that causes a persistent feeling of sadness and loss of interest), history of falling. During a review of Resident 1 ' s Minimum Data Set (MDS, standardized care and screening tool), dated 7/11/2024, indicated Resident 1 ' s cognition was intact (processes of thinking and reasoning skills) for daily decision making. The MDS indicated Resident 1 was partial /moderate assistance (helper does less than half the effort) on oral hygiene. Substantial/ maximal assistance (helper does more than half the effort. Helper lifts or hold trunks or limbs and provide more than half the effort) toilet hygiene, personal hygiene. During a concurrent observation and interview on 8/27/2024 at 3:08 PM outside Resident 1 ' s room with the License Vocational Nurse (LVN 1), LVN 1 stated observing certified nurse assistant (CNA) 1 change Resident 1 ' s diaper, which was visible from outside Resident 1 ' s room, since CNA1 did not close Resident 1 ' s privacy curtain (a cloth or screen that creates a private space for patients in a medical setting). LVN1 stated the privacy curtain should be drawn and closed while providing care to residents to ensure the dignity and respect of all residents. During an interview on 8/27/2024 at 3:15 PM with CNA 1, CNA 1 stated not fully closing Resident 1 ' s privacy curtain since CNA1 was in a hurry. CNA1 stated the privacy curtain should be fully closed to provide privacy and dignity to Resident 1. During an interview on 8/28/2024 at 12:14 PM with the Registered Nurse (RN 1), RN 1 stated privacy needs to be provided to residents all the time. (continued on next page)

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of facility ' s policy and procedure (P&P) titled Quality of life - Dignity revised date 10/2009 indicated Each resident all be cared for in a manner that promotes and enhances quality of life, dignity, respect, and individuality. Staff shall promote, maintain, and protect resident privacy, including bodily privacy during assistance with personal care and during treatment procedures. During a review of facility ' s P&P titled Dressing and Undressing the Resident revised date 10/2010 indicated The purpose of this procedure are to assist the resident as necessary with dressing and undressing and to promote cleanliness. Allow the resident as much privacy as possible while he or she is dressing or undressing. Discard all soiled clothing and linen into the soiled laundry container. During a review of facility ' s P&P titled Resident Right revised date 10/2009 indicated employees shall treat all residents with kindness respect, and dignity. The P&P also indicated federal and state laws guarantee certain basic rights to all residents of the facility. These rights include the resident ' s right to privacy and confidentiality.

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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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Reasonably accommodate the needs and preferences of each resident. 47362 Based on observation, interview, and record review, the facility failed to ensure the call light (one of the major communication technologies that link nursing home staff to the needs of residents) was accessible and addressed in a timely manner for four of six residents (Resident 2, Resident 3, Resident 4, and Resident 5). This deficient practice had the potential to result in a delay in care and services for Resident 2,3,4 and 5. Findings: 1. During a review of Resident 2 ' s admission record indicated the facility admitted Resident 2 on 3/24/2024 with diagnosis which include muscle weakness, hypertension (high blood pressure), dysphagia (difficulty swallowing). During a review of Resident 2 ' s care plan for at risk for an unavoidable fall, future fall, or injury, dated 3/24/2024 indicated interventions that included call light or alternative call light within resident reach (close enough to be touched). During a review of Resident 2 ' s Minimum Data Set (MDS, standardized care and screening tool), dated 6/19/2024, indicated Resident 2 had severely impaired with cognitive (processes of thinking and reasoning) skills for daily decision making. The MDS indicated Resident 2 was dependent (helper does all the effort to complete the activity or, the assistance of 2 or more helper required for the resident to complete the activity) on eating, oral hygiene, toileting hygiene, shower / bathe self, upper body dressing and personal hygiene. During a concurrent observation and interview on 8/28/2024 at 6:20 AM with the Certified Nursing Assistant (CNA 2), in Resident 2 ' s room, Resident 2 ' s call light was observed. CNA 2 stated Resident 2 ' s call light was not within reach of Resident 2 and was hanging on the right side of the bed rail. During a review of Resident 3 ' s admission record indicated the facility admitted Resident 3 on 5/8/2024 with diagnosis which include muscle weakness, dysphagia (difficulty swallowing), hypertension (high blood pressure). During a review of Resident 3 ' s care plan date for at risk Fall history, fall prior to admission / readmission, fall anytime in the last 30 days dated 5/8/24 indicated interventions that indicated call light within reach and answered in a timely manner. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 3 ' s Minimum Data Set (MDS, standardized care and screening tool), dated 5/10/2024, indicated Resident 3 was severely impaired with cognitive (processes of thinking and reasoning) skills for daily decision making. The MDS indicated Resident 3 was dependent (helper does all the effort to complete the activity or, the assistance of 2 or more helper required for the resident to complete the activity) on toileting hygiene, shower / bathe self, upper body dressing. Substantial/ maximal assistance (helper does more than half the effort. Helper lifts or hold trunk or limbs and provide more than half the effort) on oral hygiene and personal hygiene. During a concurrent observation and interview on 8/28/2024 at 6:25 AM with the License Vocational Nurse (LVN 2), in Resident 3 ' s room, Resident 3 ' s call light as observed. LVN 2 stated the call light was not within reach of Resident 3 ' s reach. LVN2 stated all call lights should be within residents reach at all times. 2. During a review of Resident 4 ' s admission record indicated the facility admitted Resident 4 on 6/14/2024 with diagnosis which include fall, lack of coordination, hypertension (high blood pressure). During a review of Resident 4 ' s care plan for at risk for urinary tract infection, skin breakdown, pain, and discomfort. dated 7/23/2024, indicated Resident 4 would be kept dry, clean, and comfortable. The care plan interventions indicated to provide prompt perineal (area of the body between the anus and the vulva in females, and between the anus and the scrotum in males), perianal (the area of the body surrounding the anus in particular, the skin) care. During areview of Resident 4 ' s Minimum Data Set (MDS, standardized care and screening tool), dated 4/23/2024, indicated Resident 4 ' s cognition was intact (processes of thinking and reasoning) skills for daily decision making. The MDS indicated Resident 4 was setup or clean up assistance (helper set up or clean up cleans up; resident completes activity. Substantial/ maximal assistance (helper does more than half the effort. Helper lifts or hold trunk or limbs and provide more than half the effort) on toilet hygiene, shower self /bathe self. During a concurrent observation and interview on 8/28/2024 at 6:26 AM in the hallway, Resident 4 ' s call light was observed on. CNA 2 was observed near the nursing station and LVN 2 was observed in the hallway. CNA 2 and LVN 2 did not answer the call light. At 6:30AM (4 minutes later) CNA 3 went into Resident 4 ' s room. During an interview on 8/28/24 at 6:30AM, Resident 4 stated she was very upset since she pressed her call light a long time ago. Resident 4 stated her diaper needed to be changed since she was wet. During an interview with CNA 2 on 8/28/2024 at 6:40 AM CNA 2 stated all staff should answer resident call lights. During a review of Resident 5 ' s admission record indicated the facility admitted Resident 5 on 8/23/2024 with diagnosis which include urinary tract infection (UTI - common infections that happen when bacteria, often from the skin or rectum, enter the urethra and infect the urinary tract), difficulty in walking, hypotension (abnormally low blood pressure). (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 5 ' s care plan for use of call light, dated 8/23/2024 indicated intervention to keep call light accessible at all times, remind resident on the use of call light for needs during care contact. During a review of Resident 5 ' s Minimum Data Set (MDS, standardized care and screening tool), dated 8/28/2024, indicated Resident 5 ' s cognition had moderately impaired (processes of thinking and reasoning) skills for daily decision making. During a concurrent observation and interview on 8/28/2024 at 2:00 PM, in the nurse ' s station, Resident 5 ' s call light was observed on, with a beeping sound heard, and the call light panel board lights were visible. There were five nurses at the nursing station. Registered Nurse (RN 1) stated an overhead announcement was made that Resident 5 rooms call light was turned on, however none of the five nurses in the nursing station when to addressed Resident 5 ' s call light. During an interview on 8/28/2024 at 2:00 PM with Resident 5, Resident 5 stated his diaper was wet and that he needed to be changed. Resident 5 stated facility staff do not check on Resident 5. During interview on 8/28/2024 at 3:15 PM with the Registered Nurse (RN1), RN1 stated call lights were important for residents to and should be readily accessible that the residents could call for help. RN1 further stated, if residents call light were not within reach, there was a possibility for the delay of care and could also place residents at risk for injury like falling. During a review of the facility ' s Policy and Procedure (P&P) titled Answering Call light revised date 10/2024. The purpose of this procedure is to respond to the residents request as needed. P&P general guidelines indicated be sure that the call light was plugged in at all the times. When resident is in the bed or confined to a chair to be sure the call light is within easy reach of the resident. Answer the resident call as soon as possible.