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	09/18/2024

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 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** 48152 Based on interview and record review, the facility failed to document monitoring for one of 2 sampled residents (Resident 1), for 72 hours after an alleged abuse. This deficient practice had the potential to place Resident 1 at risk for unmonitored mental, emotional changes that could negatively impact Resident 1 ' s well-being. Findings: During a review of Resident 1 ' s Face Sheet, the face sheet indicated Resident 1 was admitted to the facility on [DATE] with diagnoses that included dementia (decline in mental ability severe enough to interfere with daily functioning/life), muscle wasting (deterioration of muscle tissue) and atrophy (decrease in size of an organ or tissue) and major depressive disorder (MDD - a mental health disorder characterized by persistently depressed mood or loss of interest in activities, causing significant impairment in daily life) with psychotic features (delusions and hallucinations) . During a review of Resident 1 ' s History & Physical (H&P), dated 1/26/2024, the H&P indicated Resident 1 did not have the capacity to understand and make decisions. During a review of Resident 1 ' s Minimum Data Set (MDS - a standardized resident assessment care screening tool), dated 7/31/2024, indicated Resident 1 has a severely impaired cognitive skills (ability to think, reason and remember) for daily decision making. The MDS also indicated Resident 1 as dependent (staff does all effort needed to complete activity) with oral and personal hygiene, toileting and bathing, and partial/moderate assistance (staff does less than half the effort needed to complete the activity) with eating. During a review of Resident 1 ' s Nurses Notes, dated 9/4/2024, indicated an alleged incident of verbal abuse towards Resident 1. During a review of the facility ' s Facility-Reported Incident (undated), indicated the facility placed Resident 1 on 72 hour monitoring every shift. (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 9/16/2024 at 4:10PM, with Director of Nursing (DON), Resident 1 ' s electronic medical record was reviewed. Resident 1 ' s chart did not indicate facility staff documented 72-hour monitoring for all shifts (7AM-3PM, 3PM-11PM, and 11PM-7AM) from 9/5/2024 to 9/6/2024 (after the alleged incident of verbal abuse) for Resident 1. DON stated Resident 1 ' s medical record did not indicate documentation was completed for monitoring after an alleged verbal abuse for the 3PM-11PM and 11PM-7AM on 9/5/2024 and 9/6/2024. The DON stated per facility standard of practice, the 72-hour monitoring should be completed with any instance of alleged abuse and/or changes of conditions and documented each shift (day 7AM-3PM), evening 3PM-11PM), and night shift 11PM-7AM) during the 72-hour time frame. The DON stated, if monitoring was not documented, it was not completed. The DON stated the 72-hour monitoring was important after an incident of alleged abuse to protect and prevent any further abuse and for the resident ' s safety. The DON stated Resident 1 could possibly experience anxiety or abuse if the 72-hour monitoring was not done and staff could not conclude if Resident 1 was safe. During an interview on 9/16/2024 at 4:31PM with Licensed Vocational Nurse 1 (LVN 1), LVN 1 stated it was the facility ' s practice to monitor the resident for 72 hours after an alleged abuse. LVN 1 stated each shift should monitor and document the 72-hour monitoring in the resident ' s medical record. During a concurrent interview and record review on 9/17/2024 at 11:10 AM with Medical Records Nurse (MRN), the facility ' s policy titled Charting and Documentation, revised 4/2017, was reviewed. MRN stated the facility ' s standard of practice was to complete the 72-hour monitoring to ensure the residents were followed up. During a concurrent interview and record review on 9/17/2024 at 3:26PM with the DON, the facility ' s policy titled, Charting and Documentation, revised 4/2017, was reviewed. The policy indicated 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. And documentation will be complete. The DON stated the facility ' s standard of practice for 72-hour monitoring should be conducted to ensure consistency with all staff.