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	01/07/2025

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 45523 Based on interviews and record review, the facility failed to provide adequate supervision to prevent accidents for two (2) out of the four (4) sampled residents (Resident 1 and 4) by: 1. Failing to monitor Resident 1 at least every two (2) hours and as needed in accordance with the resident's care plan for Resident noted of picking up things quickly and hides it. On 1/3/2025, Resident 1 was observed with a ring (not the resident's ring) on the resident's left hand's middle finger. This deficient practice has resulted in Resident 1 's left hand middle finger to get swollen and appeared to have pus (a thick, usually yellowish-white, fluid matter that is formed as part of an inflammatory response typically associated with an infection) due to the ring that does not fit the resident and staff was not able to remove. Resident 1 was transferred to the hospital on 1/3/2025 and received intravenous (IV- way of giving the drug or substance through a needle or tube inserted into a vein) antibiotics (medicine that fight bacterial infections delivered into a vein by injection) in the General Acute Care Hospital (GACH) 1 emergency room (ER) and ring removal via electric saw was used to remove the ring. 2. Failing to monitor Resident 4's whereabouts while resident is out for a dental appointment and that the resident was back to the facility after the resident left for his dental appointment on 12/27/2024 at 9 AM. This deficient practice placed resident at risk for harm and injury. On 12/27/2024 at 6 PM (9 hours and from when the reisdent left the facility) the facility noted the resident was not back from the dental appointment) and at 7:15 PM, the facility verified from GACH 2 that Resident 2 was admitted at GACH 2 due to nausea, vomiting and low oxygen saturation (measure of how much oxygen in the blood). Findings: (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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	1. During a review of the admission record indicated Resident 1 was admitted to the facility on [DATE] with diagnoses that included but not limited to unspecified dementia (a condition characterized by progressive or persistent loss of intellectual functioning, especially with impairment of memory and abstract thinking, and often with personality change, resulting from organic disease of the brain), age related osteoporosis (a bone disease that causes bones to become weaker and more likely to break), and anxiety disorder (condition in which a person has excessive worry and feelings of fear, dread, and uneasiness). During a review of Resident 1's Care Plan dated 10/20/2021 indicated, Resident noted of picking up things quickly and hides it. Interventions indicated, monitor resident more often at least every 2 hours and as needed. During a review of Resident 1's Care Plan dated 2/19/2024 indicated, Resident takes things from staff and other residents. Resident walks around the facility .trying to hide things that she takes at random. During a review of Resident 1's Care Plan dated 2/19/2024 indicated, the reisdent is at risk for elopement (the act of leaving the facility without facility staff's knowledge and supervision) and wandering (traveling aimlessly from place to place). Approach/ Interventions indicated to maintain safe and hazard free environment, visual monitoring, or resident's whereabouts every shift. During a review of the History and Physical (H&P) report completed on 10/25/2024, indicated Resident 1 does not have the capacity to understand and make decisions. During a review of Resident 1's Minimum Data Set (MDS - resident assessment tool), dated 11/12/2024, indicated Resident 1 is nonverbal (does not speak). During a record review of Resident 1's Physician Order Sheet dated 1/03/2025 indicated, Transfer to Acute Hospital. During a review of Resident 1's Nursing Daily Note dated 1/03/2025 at 8:33PM indicated, at 5:30 PM Certified Nurse Assistant (CNA) informed me that resident left hand middle finger is swollen. Came to assess Resident 1, left hand middle finger and is swollen and appears to have pus. Resident left hand middle finger has a ring on it At 6:50 PM, ambulance came to transfer Resident to the hospital's ER. During a review of Resident 1's hospital admission medical record dated 1/03/2025 indicated Resident 1 was admitted to hospital'sER on [DATE] with problem list of cellulitis (bacterial infection of the skin that causes redness, swelling warmth and pain) of left middle finger, laceration (skin tear) of left middle finger with foreign body without damage to nail and swelling of left middle finger. During a review of Resident 1's hospital H&P Notes dated 1/04/2025 at 11:08 AM, indicated Resident 1 was noted to have significant left hand third digit (finger) swelling and redness distal (from the point of attachment) to the retained ring. The H&P notes also indicated X-ray (type of radiation that produces an image of the inside of the body) of the left hand revealed significant soft tissue swelling of the left third digit distal to foreign body/ring. Resident 1 was given IV antibiotics in the ER and ring removal via electric saw was used to remove the ring. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview with the facility Administrator (Admin) on 1/07/2025 at 9:45 AM, Admin stated, we noticed her ring finger was swollen, this resident (Resident 1) is kleptomaniac (a mental health disorder that causes a person to steal items they do not need). Admin also stated, the ring found on Resident 1's left middle finger was not Reisdent 1's ring and the facility did not know who the ring belongs to. Admin added, Reisdent 1 is ambulatory (able to walk) and goes into other residents' rooms, and in some instances she (Reisdent 1) also goes into the facility staff's office. Admin stated, if the staff cannot find their keys, or they some of their belongings went missing, after a day or two, the facility will find them in Resident 1's bed or in the resident's closet. Admin also stated, So, we know it, once someone is missing an item, we know it is Resident 1 that took it. During an interview with License Vocational Nurse (LVN) 1 on 1/07/2025 at 10:51 AM, LVN1 stated, I got the report (on 1/3/2025), the CNA told me the CNA noticed the residents left middle finger was swollen. I assessed it and it did seem like it had pus in it because she had a ring on it. We do not know if it was her (Reisdent 1) ring or not, but it was tight. She has history of hoarding things in her room, we sometimes find utensils in Reisdent 1's drawer. During a concurrent interview and record review with the facility's nurse consultant on 1/07/25 at 1:54 PM, Reisdent 1's Car e Plan for at risk for elopement and wandering dated 2/19/2024 and Care Plan for the behavior of picking up thing quickly and hides it dated 10/20/2021 were reviewed. The nurse consultant stated, according to the Residents 1's care plan, all current interventions for resident's wandering and taking things should have been revised to reflect additional interventions such as 1:1 supervision (a single healthcare professional is directly overseeing and monitoring one resident at all times, providing constant attention and support, usually used when a patient is at high risk of harm and requires close observation and immediate intervention) to monitor closely and keep the resident safe. The nurse consultant also confirmed there was no documentation indicating the resident was being monitored every 2 hours and as needed as indicated in the care plan. 2. During a review of the admission record indicated Resident 4 was admitted to the facility on [DATE] with diagnoses that included but not limited to bipolar disorder (a mental illness that causes clear shifts in a person's mood, energy, activity levels, and concentration), major depressive disorder (a mental health condition that involves persistent feelings of sadness, hopelessness, and a loss of interest in activities), anxiety disorder (a condition in which a person has excessive worry and feelings of fear, dread, and uneasiness), and lack of coordination and back pain. During a review of the H&P report completed on 10/25/2024, indicated Resident 4 has the capacity to understand and make decisions. During a review of Resident 4's MDS- assessment tool, dated 11/15/2024, indicated Resident 4 is independent (resident completes all activities with no assistance from a helper) for the activities of daily living (ADLs- which are the basic tasks people perform to care for themselves. These tasks include eating, dressing, bathing, and using the toilet) and is independent for toileting hygiene, showers, and dressing. During a review of Resident 4's care plan initiated 2/5/2024 and re- evaluated on 2/2025, indicated Resident 4 is at risk for elopement or wandering. During Resident 4's Physician Order Sheet dated 12/26/2024 indicated, Dental appointment on 12/27/24 at 9:00 AM (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a record review of Resident 4's Nurses Notes dated 12/27/2024 at 8:57 AM indicated, Resident requested all pertaining documents and departed via Transportation 1 to dental appointment. During a record review of Resident 4's Nurses Notes dated 12/27/2024 at 8:48 PM indicated, at 6:30 PM resident is not back from his dental appt. Called dental office and it is close already. Called resident cell phone but it is not in service. Called GACH 2's ER at 7:15 PM and spoke to GACH 2's staff who stated resident was admitted at GACH 2 complaining of nausea, vomiting and low O2 sat. Per Hospital staff the resident went there himself. During an interview with the facility Administrator (Admin) on 1/07/25 at 10:36 AM, Admin stated, Resident 4 went out for a dental appointment on Friday 12/27/24 around 9 AM. During an interview with License Vocational Nurse (LVN) 1 on 1/07/25 at 10:56 AM, LVN 1 stated on 12/27/2024, LVN 1's shift was from 3 PM-11:30 PM and Resident 4 had left the facility to go to the resident's dental appointment at 9 AM that morning. LVN1 stated, he noticed Resident 4 had not returned to the facility around 6 PM. LVN1 stated, I called the dental office around 6 PM. I was wondering why he was not back. When I called the dental office, it was closed already. LVN 1 stated around 7:15 PM, LVN 1 called GACH 2's ER and verified with GACH 2's staff that Resident 4 was admitted at their ER with low oxygen and that the resident went there by himself. During a phone interview on 1/07/25 at 12:20 PM with Dental Office's Receptionist, the receptionist stated Resident 4 arrived at the dental office on 12/27/2024 at 9:10 AM, checked in and asked for the bathroom code and never came back for the dental appointment. During a concurrent interview on 1/07/25 at 12:43 PM with Admin, Admin stated Resident 4 should not have been gone more than 2 to 3 hours from the dental appointment. Admin added, Resident 4 was supposed to be back when after the dental appointment and the facility staff should have checked to see how come the Resident 4 was not back after 2 to 3 hours from the dental appointment. Admin also stated, during change of shift endorsement, the licensed nurses should have followed up. Admin confirmed the facility is still considered responsible for the patient when the resident is out of the facility for a doctor's appointment. Admin stated, licensed nurses should have called the dental office sooner because we do not know what can happen, the facility staff needs to be aware of the resident's whereabout even when out for a dental appointment. Admin also stated there was potential for resident harm by the facility not knowing where the reisdent was at from 9 AM to 6 PM. Admin also stated, Honestly, I was not here so I do not know if they followed up with the dentist, I was just informed he (Reisdent 4) was in the hospital. During an interview with the facility's nurse consultant, the consultant stated Resident 4 was out of the facility about 9 hours and 30 minutes and that the patient should be back within reasonable time which is 2 to 4 hours after the resident's dental appointment. The nurse consultant also stated, We thought maybe he went out to buy something while he was out. But the nurse should have called to ask where he was at. The resident is the facility's responsibility. We should be always aware of his (Resident 4) whereabouts and try to keep him from harm. The nurse consultant stated, Reisdent 4 should have been contacted within reasonable amount of time about 2 to 4 hours after the dental appointment and the facility staff should have not waited for more than 4 hours before they try to locate/ look for the reisdent. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview with the facilities MDS Nurse on 1/07/25 at 2:31 PM, MDS Nurse stated, he (Reisdent 4) is at risk for decline due to his age but for other underlying medical conditions he is stable, he did not have history of low oxygen, first time it happened. However, there should be an updated change of shift report to notify staff that the resident had been gone for more than 4 hours, he was at risk for harm, it is the protocol for staff to communicate. If there is change of shift, it should have been communicated for them to check on his (Reisdent 4) status. MDS Nurse stated, it was over 8 hours that the facility staff realized that Reisdent 4 was not back at the facility from dental appointment. MDS Nurse stated if resident was not back at the facility within 4 hours from a dental appointment, that should have raised a concern. MDS Nurse stated, it was not acceptable and places the resident at risk for accidents. During an interview with RN on 1/10/25 at 2:29 PM, RN stated, During my shift on 12/27/2024 which is 7 AM to 3 PM, I did not check the resident's (Resident 4) whereabouts. I should have because anything could have happened to him while he was out of the facility. During a concurrent interview with RN on 1/10/25 at 2:43 PM, RN stated, Before my shift ended on 12/27/2024 around 3 PM, I did not physically check to see if the resident (Resident 4) was back. I did inform the other nurse on change of shift that he (Resident 4) was out on appointment. RN also stated, RN did not think to call the dental office, and that RN should have. RN also stated, now I am thinking about it, and it is something that possibly could have happened to Reisdent 4. We are liable if something happened to Resident 4, for he is our patient. I was not thinking that he was in danger. I would have followed up and called, but I guess I was not thinking. During a review of the facility's policy and procedure (P&P) titled Safety and Supervision of Residents, revised July 2017, indicated, Our facility strives to make the environment as free from accident hazards as possible. Resident safety and supervision and assistance to prevent accidents are facility-wide priorities. In addition, the P&P indicated the following: Individualized, Resident-Centered Approach to Safety 1. Our individualized, resident centered approach to safety addresses safety and accident hazards for individual residents. 2. The care team shall target interventions to reduce individual risks related to hazards in the environment, including adequate supervision and assistive devices. 3. Monitor the effectiveness of interventions shall include the following: a. Ensuring that interventions are implemented correctly and consistently b. Evaluating the effectiveness of interventions c. Modifying or replacing interventions as needed; and d. Evaluating the effectiveness of new or revised interventions Systems Approach to Safety (continued on next page)

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