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	01/29/2025

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 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** 46919 Based on interview and record review, the facility failed to provide the necessary care and services in accordance with professional standards of practice (guidelines that outline the expectations and requirements for professionals) to attain or maintain the highest practicable physical well-being (highest possible level of functioning and well- being) for one of two sampled residents (Resident 1) by failing to: 1. Notify and coordinate with Resident 1's primary physician regarding Resident 1's neurologist ([NAME] -a medical doctor who is an expert in diagnosing and treating diseases and conditions of the brain, spinal cord, and nerves) order to continue Resident 1's lacosamide medication (Vimpat - a medication used to manage and control partial seizures [brief episodes of abnormal brain activity that can cause involuntary movements, loss of consciousness, or other symptoms]) on 11/5/2024. The facility did not notify [NAME] about Resident 1's lacosamide was stopped on 11/2/2024. 2. Notify and coordinate with Resident 1's primary physician the recommendations of Resident 1's Doctor of Osteopathic Medicine (DOM - a licensed physician who uses a whole-body, Resident-centered approach to medicine) to start Acetyl-L-carnitine (a medication that turns fat into energy and treats elevated ammonia), zinc (a nutrient important for wound healing) and to increase Vitamin D3 (a vitamin used to treat and prevent bone disorders). These deficient practices resulted in failure in the delivery of necessary care and services for Resident 1 and had the potential to cause seizure activity and unnecessary hospitalization . Findings: 1. During a review of Resident 1's Face Sheet (Admission Record), the Face Sheet indicated Resident 1 was initially admitted to the facility on [DATE] and was readmitted on [DATE] with diagnoses that included cerebral infarction (a condition where blood flow to the brain is interrupted, causing brain tissue to die), epilepsy (a chronic neurological condition characterized by recurrent seizures), and moderate protein-calorie malnutrition (inadequate intake of food that leads to changes in the body). (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 1's Minimum Data Set (MDS- a resident assessment tool), dated 11/27/2024, the MDS indicated Resident 1 was assessed having severely impaired (never/rarely made decisions) cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decision making. The MDS also indicated Resident 1 was dependent (helper does all of the effort, Resident does none of the effort to complete the activity) with oral hygiene, toileting hygiene, upper/lower body dressing, roll left and right, sit to lying, and tub/shower transfer. During a review of Resident 1's Neurology Assessment and Plan, written by the [NAME], dated 11/5/2024, the Assessment and Plan, indicated the following: Changed Vimpat 10 mg/milliliter (ml-unit of measurement) oral solution, 20 ml (200 milligram [mg]) twice a day (BID), 90 days starting 11/5/2024, Ref (refill) x 2. Counseled on medication titration potential side effects and importance of compliance Counseled on SUDEP (sudden unexpected death in epilepsy) risk, importance of medication compliance in minimizing risk During a review of Resident 1's Neurology Assessment and Plan, dated 1/7/2025, the [NAME] indicated Resident 1 was stable on lacosamide 200 milligram (mg) BID though it is unclear if Resident 1 has been getting it recently- will confirm with the Skilled Nursing Facility (SNF) and recheck EEG (a medical test that measures the electrical activity of the brain). During a concurrent observation and interview of Resident 1's medications in the medication cart with Licensed Vocational Nurse 1 (LVN 1), on 1/28/2025, at 12:39 PM, LVN 1 stated Resident 1 was ordered to take lacosamide when she was admitted in 8/24/2024. LVN 1 stated Resident 1's did not receive lacosamide from the first week of November 2024 to the beginning of January 2025 because it was not ordered on or after 11/3/2024. LVN 1 stated Resident 1 lacosamide was restarted on 1/8/2025. During a concurrent interview and record review on 1/28/2025, at 12:48 PM, with Registered Nurse 1 (RN 1), Resident 1's November 2024 Physician Order Sheet was reviewed. RN 1 stated the Physician Order Sheet indicated Resident 1 was ordered to take lacosamide 200 mg tablet via gastrostomy (G-tube- a surgical opening fitted with a device to allow feeding to be administered directly to the stomach common for people with swallowing problems) every 12 hours for thirty days starting 10/3/2024. During the same concurrent interview with RN 1 on 1/28/2025, at 12:48 PM, Resident 1's November 2024 Medication Administration Record (MAR) was reviewed. RN 1 stated according to Resident 1's MAR, the lacosamide was last administered to Resident 1 on 11/2/2024, at 10AM. RN 1 stated Resident 1 did not receive lacosamide from 11/2/2024 at 10PM until 1/7/2025 (66 days). RN 1 stated she did not know why lacosamide was not reordered after 11/2/2024. RN 1 stated it was her responsibility to inform and clarify with the [NAME] if the lacosamide was going to be continued or discontinued before 11/2/2024 and it should have been relayed to Resident 1's primary physician. RN 1 stated lacosamide was a medication to control seizure and should not be discontinued suddenly. Resident 1 stated lacosamide needed to be weaned (to slowly decrease the dose of a drug over time to reduce the risk of withdrawal symptoms) before discontinuing to prevent the reoccurrence of seizures. RN 1 stated she was not aware of the [NAME]'s note on 11/5/2024 to continue Resident 1's lacosamide 200 mg twice daily for 90 days. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with the Director of Nursing 1 (DON 1- previous DON), on 1/28/2025, at 5:04 PM, the DON 1 stated facility staff should have clarified with the [NAME] if Resident 1's lacosamide should be continued or discontinued and it should have been relayed to Reisdent 1's primary physician so the facility can get the physician's order. The DON stated suddenly stopping lacosamide can cause seizures. During an interview with the [NAME], on 1/29/2025, at 10:060 AM, the [NAME] stated Resident 1's lacosamide was never discontinued. The [NAME] stated he never gave the facility an order to stop administering lacosamide to Resident 1. The [NAME] stated stopping the medication abruptly would cause breakthrough seizures and headaches. 2. During a review of Resident 1's Referrals/Response Letter, written by the DOM, sent on 11/6/2024, the Referrals/Response Letter indicated orders for the facility to: Continue Vitamin D3 10,000 International Unit (IU- unit of measurement) powder emptied from capsule, mixed with 2 ounces (oz- unit of measurement) of free water and administered by G-tube one time daily. Continue Zinc 30 mg powder emptied from capsule, mixed with 2 ounces of free water and administered by G-tube one time daily. During a review of Resident 1's Referrals/Response Letter, written by the DOM, sent on 1/7/2025, the Referrals/Response Letter indicated a new medication order for the facility to begin N-Acetyl-L-Carnitine 500 mg capsules dose is 1 capsule daily- open 1 capsule and mix with 5.5 oz of juice and administered by G-tube one time daily in the PM to treat elevated ammonia (a waste product of protein metabolism in the body). The letter also indicated ongoing medical orders from previous visits including to continue with Vitamin D3 10,000 IU powder emptied from 1 capsule, mixed with 2 ounces of free water and administered by G-tube daily and to begin Zinc 30 mg powder emptied from capsule, mixed with 2 ounces of free water and administered by G-tube 1 time daily. During a concurrent interview with RN 2 and record review on 2/7/2025 at 3:11 PM, Resident 1's January 2025 Physician Order Sheet was reviewed. RN 2 stated according to the order sheet, N-Acetyl-L-Carnitine 500 mg and Zinc 30 mg are not in Resident 1's Physician Order Sheet. RN 2 stated both medications are currently not being administered to Resident 1. RN 2 also stated Resident 1's January 2025 Physician Order Sheet indicated an order for Vitamin D3 1,000 IU once daily and not Vitamin D3 10,000 IU once daily. During an interview with the Director of Staff Development (DSD 1), on 2/7/2025 at 4:08 PM, DSD 1 stated it was the responsibility of the licensed nurse to inform the primary physician that DOM 1 ordered Resident 1 to take Vitamin D3 10,000 IU once daily and to take Zinc 30 mg once daily on 11/6/2024 and N-Acetyl-L-Carnitine 500 mg daily on 1/7/2025. DSD 1 stated there was no documented evidence in Resident 1's medical records that Resident 1's primary physician was not informed regarding Resident 1's new medication orders from DOM 1 about Zinc and Vitamin D3 on 11/6/2024 and N-Acetyl-L-Carnitine on 1/7/2025. DSD 1 stated it was important for licensed staff to communicate new medication orders or referrals from Resident 1's [NAME] and DOM 1 to the primary physician so the primary physician was aware and updated regarding Resident 1's care and treatment plans. DSD stated it was important for Resident 1 to take the medications as ordered by the DOM 1 because N-Acetyl-L-Carnitine was for elevated ammonia levels, and Vitamin D3 and Zinc were supplements for bones, wounds, and immunity. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with the DON 2 (new DON that replaced DON 1) on, 2/10/2025, at 11:42 AM, the DON 2 stated any orders from the Resident 1's special clinic appointments and consulting (outpatient) physicians should be communicated to the primary physician. The DON 2 stated the primary physician should always be informed and updated regarding changes in the Resident 1's medications. The DON 2 stated Resident 1 can get improper care if the primary physician was not aware of the resident's new medication orders from the [NAME] and DOM. During a review of the facility's policy and procedure (P&P), titled, Medications Therapy, revised on 4/2007, the P&P indicated the following: Medication use shall be consistent with an individual's condition, prognosis, values, wishes, and responses to such treatments. Upon or shortly after admission, and periodically thereafter, the staff and practitioner (assisted by the consultant pharmacist) will review an individual's current medication regimen, to identify whether: o there is a clear indication for treating that individual with the medication; o the dosage is appropriate; o the frequency of administration and duration of use are appropriate; and o potential or suspected side effects are present Periodically, and when circumstances are present that represent a greater risk for medication-related complications, the staff and practitioner will review the medication regimen for continued indications, proper dosage and duration, and possible adverse consequences. The medical director and consultant pharmacist shall collaborate to address issues of medication prescribing and monitoring with the practitioners and staff.