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	02/25/2025

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48678 Based on observation, interview, and record review, the facility failed to report an injury of unknown origin for one of one resident (Resident 1), who was observed with unexplained swelling (a raised/ enlarged, curved shape on the surface of your body which appears as a result of an injury or an illness) on the resident's right hand on 1/26/2025. This failure compromised Resident 1's safety and well-being by delaying appropriate medical evaluation and intervention. Findings: During a review of Resident 1's Admission Record, the Admission Record indicated Resident 1 was admitted to the facility on [DATE] with diagnosis of dementia (a progressive state of decline in mental abilities), Parkinson's disease (a progressive disease of the nervous system marked by tremor, muscular rigidity, and slow imprecise movement), and ataxia (a neurological condition that affects coordination, balance, and movement. It is caused by damage to the cerebellum, the part of the brain that controls these functions). During a review of Resident 1's Minimum Data Set (MDS- resident assessment tool), dated 1/30/2025, the MDS indicated Resident 1 had severely impaired cognition (ability to think, remember and make decisions). The MDS indicated Resident 1 required partial assistance (helper does less than half the effort to lift, hold, or support trunk or arms and legs, but provides less than half the effort) for eating, toileting, oral hygiene, rolling left and right, sitting down, lying down, transferring to a chair and bed, walking ten feet, and lying to sitting on side of bed. The MDS indicated Resident 1 was dependent (helper does all of the effort, resident does none of the effort to complete the activity) on staff to shower and required maximal assistance (helper does more than half the effort to lift or hold trunk or limbs and provides more than half the effort) for upper and lower body dressing, putting on footwear, and personal hygiene. During a review of Resident 1's nursing progress notes, dated 1/26/2025, the progress note indicated Resident 1's wife had informed the Registered Nurse (RN) that Resident 1's hand looked swollen, and Resident 1 was complaining of pain when the resident's wife touched the resident's middle finger. The progress note indicated Resident 1's right hand looked bigger than the left hand. (continued on next page)

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

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 1's Patient Report from Laboratory 1, dated 1/27/2025, indicated Resident 1 had undergone a Radiograph (XRAY- type of medical imaging that creates pictures of bones and soft tissue) of his right hand and localized swelling, mass and a lump (abnormal bumps or mass under the skin) were identified. During an interview on 2/25/2025 at 1:01 PM with the Assistant Director of Nursing (ADON), the ADON stated any injury with unknown cause is supposed to be reported within two hours to the Administrator and the Director of Nursing (DON) to provide residents with treatment if needed, investigate the cause of the injury, and protect residents from potential abuse (willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish) or neglect (the failure of the facility, its employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish or emotional distress). During an interview on 2/25/2025 at 1:37 PM with the Administrator, the Administrator stated she was not informed about Resident 1's unexplained swelling on the right hand on 1/26/2025. The Administrator stated the RN should have reported this unusual occurrence immediately to the Administrator and the facility should have reported the incident within 24 hours of the occurrence to the state agency and should have conducted an investigation to determine how Resident 1 was injured. During a review of the facility's policy and procedure (P&P) titled Unusual Occurrence Reporting, dated December 2007, the P&P indicated unusual occurrences shall be reported via telephone to appropriate agencies as required by current law/regulations within 24 hours of such incident. A written report detaining the incident and actions taken by the facility after the event shall be sent to the state agency within 48 hours of reporting the event as required by federal and state regulations.

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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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48678 Based on observation, interview, and record review, the facility failed to revise and update the Care Plan (CP- a tool that helps nurses and other care team members organize aspects of patient care according to a timeline, and allows them to think critically and holistically in a way that supports the patient's physical, psychological, social, and spiritual care) for one of one sampled resident (Resident 1), who had a fall incident on 2/11/2025. This failure resulted in a lack of new fall prevention interventions, placing Resident 1 at risk for another fall incident and/ or injury. Findings: During a review of Resident 1's Admission Record, the Admission Record indicated Resident 1 was admitted to the facility on [DATE] with diagnosis of dementia (a progressive state of decline in mental abilities), parkinson's disease (a progressive disease of the nervous system marked by tremor, muscular rigidity, and slow imprecise movement), and ataxia (a neurological condition that affects coordination, balance, and movement. It is caused by damage to the cerebellum, the part of the brain that controls these functions). During a review of Resident 1's Minimum Data Set (MDS- resident assessment tool), dated 1/30/2025, the MDS indicated Resident 1 had severely impaired cognition (ability to think, remember and make decisions). The MDS indicated Resident 1 required partial assistance (helper does less than half the effort to lift, hold, or support trunk or arms and legs, but provides less than half the effort) for eating, toileting, oral hygiene, rolling left and right, sitting down, lying down, transferring to a chair and bed, walking ten feet, and lying to sitting on side of bed. The MDS indicated Resident 1 was dependent (helper does all of the effort, resident does none of the effort to complete the activity) on staff to shower and required maximal assistance (helper does more than half the effort to lift or hold trunk or limbs and provides more than half the effort) for upper and lower body dressing, putting on footwear, and personal hygiene. During a review of Resident 1's Interdisciplinary Team Conference (IDT-a group of professionals from different disciplines who work together to achieve a common goal)/ Post Fall Assessment, dated 2/11/2025, the IDT/ Post Fall Assessment indicated Resident 1 keeps getting up unassisted, and gets combative when redirected. During a review of Resident 1's Fall Risk Assessment, dated 2/11/2025, indicated Resident 1 was at high risk for potential falls and a fall prevention care plan and protocol should be implemented or updated. During a review of Resident 1's Care Plan (CP) dated from 9/4/2024 to 2/25/2025, the CP indicated Resident 1 had a fall when he attempted to go to the bathroom without assistance, and implementations to take were monitor balance daily before ambulation and assist as necessary. The CP for fall did not indicate it was updated after the resident's fall on 2/11/2025. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 2/25/2025 at 12:20 PM with Licensed Vocational Nurse (LVN), the LVN stated she could not find a revised/ updated CP for Resident 1's status post fall on 2/11/2025 and according to the facility's protocol, any licensed nurse can update the CP and place residents on 72-hour monitoring after the fall. LVN stated, Resident 1's last CP was updated on 9/4/2024 after Resident 1 had another fall when he attempted to go the bathroom without assistance. During an interview on 2/25/2025 at 1:01 PM with the Assistant Director of Nursing (ADON), the ADON stated anytime there is a change of condition with a resident, the CP should be revised and updated by the facility to reflect any additional or new interventions to prevent further falls and potential injury. During a review of the facility's policy and procedure (P&P) titled Care Plans, Comprehensive Person-Centered, dated March 2022, indicated Care Plans reflect current recognized standards of practice for problem areas, are revised as information about the residents' condition change and at least quarterly. During a review of the facility's policy and procedure (P&P) titled Falls and Fall Risk, Managing, indicated the staff with the input of the attending physician will implement a resident-centered fall prevention plan to reduce the specific risk factors of falls for each resident at risk or with a history of falls. If the resident continues to fall, staff will re-evaluate the situation and change current interventions.