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	03/20/2025

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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48152 Based on observation, interview and record review, the facility failed to provide appropriate pressure ulcer (localized, pressure-related damage to the skin and/or underlying tissue usually over a bony prominence) management for two of three sampled residents (Resident 2 and 3), by failing to ensure the Low Air Loss mattresses (LAL- a type of mattress used for residents who are at risk of developing pressure sores or already have pressure sores) were at the correct weight settings for the residents. This failure resulted in inadequate therapy from the LAL mattresses, with the potential to worsen Resident 2 and 3's current pressure ulcers. Findings: 1. During a review Resident 2's Face Sheet (admission record), the Face Sheet indicated Resident 2 was admitted to the facility on [DATE] with diagnoses that included pressure ulcer of sacral region (the area of the lower back, specifically encompassing the sacrum [triangular bone formed at the base of the spine]), unstageable (full-thickness skin and tissue loss in which actual depth of the ulcer is completely hidden by slough [dead tissue that is usually yellow, tan, gray, or green in color, moist and stringy in texture] and/or eschar [dead tissue that is usually black, brown, or tan in color, may appear scab-like, usually firmly attached to the base, sides and/or edges of the wound]), adult failure to thrive (a decline caused by chronic diseases and functional impairments which can cause weight loss, decreased appetite, poor nutrition, and inactivity) and lack of coordination. During a review of Resident 2's March 2025 Physician Order Sheet, the Order Sheet indicated an order for Low Air Loss Mattress for wound management and prevention, with order date on 12/31/2024. During a review of Resident 2's Braden Scale (a validated tool used to assess a patient's risk of developing pressure ulcers by evaluating six key factors: sensory perception, moisture, activity, mobility, nutrition, and friction/shear) for Predicting Pressure Sore Risk, dated 12/31/2024, the Braden Scale indicated Resident 2 was at risk for pressure ulcer development with risk factors of constant skin moisture (potentially kept moist by almost constantly by sweat, urine, etc. and dampness is detected every time resident is moved or turned) and occasional walking (spends majority of each day/shift in bed or chair). (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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 2's Skin Integrity - Alteration In care plan (a document that outlines the facility's plan to provide personalized care to a resident that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs), dated 12/31/2024, the care plan indicated the use of a LAL mattress for Resident 2's sacrococcyx (the region at the bottom of the spine, where the sacrum and coccyx bones meet) unstageable pressure ulcer. During a review of Resident 2's Surgical Consult, dated 1/4/2025, the Surgical Consult indicated Resident 2 had an unstageable sacrococcyx pressure injury/ulcer with treatments including LAL mattress. During a review of Resident 2's Minimum Data Sheet (MDS - a resident assessment tool) dated 1/6/2025, the MDS indicated Resident 2 had intact cognitive skills (ability to understand and make decisions). The MDS also indicated Resident 2 was substantial/maximal assistance (helper does more than half the effort needed to complete the activity) with toileting, bathing, personal hygiene, lower body dressing and partial/moderate assistance (helper does less than half the effort needed to complete the activity) with rolling left and right. The MDS also indicated Resident 2 had two unstageable (slough and/or eschar) pressure ulcers with treatments that included a pressure reducing device for her bed. 2. During a review of Resident 3's Admission Record, the Admission Record indicated Resident 3 was admitted to the facility on [DATE] with diagnoses that included cerebral infarction (also known as a stroke; refers to damage to the tissues in the brain due to a loss of oxygen to the area), general weakness, difficulty walking and hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body). During a review of Resident 3's MDS dated [DATE], the MDS indicated Resident 3 had severely impaired cognitive skills. The MDS also indicated Resident 3 was substantial/maximal assistance with eating and rolling left and right and dependent (helper does all effort needed to complete activity) with toileting, bathing, personal and oral hygiene and dressing. The MDS also indicated Resident 3 had one unstageable (slough and/or eschar) pressure ulcer with treatments that included a pressure reducing device for the resident's bed. During a review of Resident 3's March 2025 Physician Order Sheet, the Order Sheet indicated an order for Low Air Loss Mattress for wound management and prevention ordered on 3/7/2025. During a review of Resident 3's Braden Scale for Predicting Pressure Sore Risk, dated 3/6/2025, the Braden Scale indicated Resident 3 was at risk for pressure sore development with risk factors of very limited mobility (ability to change and control body position), a chair fast activity level and problem with friction (the mechanical force exerted on skin that is dragged across any surface) and shearing (the interaction of both gravity and friction against the surface of skin). During a review of Resident 3's Skin Integrity - Alteration In care plan, dated 3/7/2025, the care plan indicated the use of a LAL mattress for Resident 3's sacrococcyx unstageable pressure ulcer. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent observation and interview on 3/20/2025 at 8:49AM with Certified Nurse Assistant 1 (CNA 1) in Room A, Resident 2 was observed laying on a LAL mattress with the weight setting set between 180 pounds (lbs.) - 210 lbs. Resident 3 was observed laying on a LAL mattress with the weight setting between 210lbs - 250lbs. CNA 2 stated the LAL mattress setting for both Resident 2 and Resident 3 were at 210lbs and she does not know Resident 2 or Resident 3's current weights. During a concurrent observation and interview on 3/20/2025 at 9:14AM with Treatment Nurse 1 (TN 1), in Room A, Resident 2 was observed laying on a LAL mattress with the weight setting set between 180 pounds (lbs) - 210 lbs. Resident 3 was observed laying on a LAL mattress with the weight setting between 210lbs - 250lbs. TN 1 stated Resident 2's LAL mattress weight was set at 200lbs and Resident 3's LAL mattress was set at 220lbs. TN 1 stated the LAL mattress setting is determined by the Resident's current weight and is checked by licensed nursing staff daily. TN 1 stated she does not know the current weight of Resident 2 and Resident 3 and will need to check the residents' medical records. During a concurrent interview and record review on 3/20/2025 at 9:43AM with Restorative Nurse Assistant (RNA) 1, the facility Weight Book was reviewed. The weight book indicated on 3/4/2025, Resident 2's weight is 101lbs. The weight book also indicated Resident 3's weight on 3/18/2025is 114 lbs. RNA 1 stated she used a chair scale to weigh both residents and then recorded it in the weight book. During an interview on 3/20/2025 at 12:28PM with TN 1, TN 1 stated the current weight for Resident 2 is 101 lbs. and Resident 3 is 114 lbs. TN 1 stated the LAL mattress settings for both Resident 2 and 3 were inappropriate, the LAL mattress settings did not reflect Resident 2 and 3's current weights and should have been adjusted to the LAL mattress setting. TN 1 stated the appropriate LAL mattress setting for Resident 2 should be a little more than 100 and Resident 3 should be set at 114 to 120. TN 1 stated the function of the LAL mattress is to circulate air and prevent pressure on pressure areas [of the body] and if the LAL mattress is not on the correct settings, the function of the bed is not doing its purpose. During an interview on 3/20/2025 with the Director of Nursing (DON) at 12:58PM, the DON stated LAL mattresses are used to prevent wounds, and licensed staff are to set and check the LAL mattress settings. The DON stated the LAL mattress setting should beset to the residents' current weight. The DON stated if the LAL mattress setting is set at a weight that is inappropriately higher than the resident's weight, the LAL mattress is too firm which does not allow space for circulation between the resident's body and mattress so heat and moisture will not move and can cause or worsen the pressure ulcer. During a review of the facility's Policy and Procedure (P&P) titled Support Surface Guidelines, revised 10/2010, the P&P indicated pressure-reducing and pressure-relieving devices are to promote comfort for all bed-bound or chairbound residents, prevent skin breakdown, promote circulation and provide pressure relief or reduction. During a review of the facility's P&P titled Use of Support Surface or Mattress for Pressure Injury Management and Treatment, dated 4/20/2024, the P&P indicated LAL mattresses will be set according to the resident's weight to optimize effectivity.