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	04/01/2025

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 - Few	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** 46919 Based on interview and record review the facility failed to prevent an accident by failing to monitor one of two sampled residents (Resident 1) for constant kicking of leg when severely anxious or agitated in accordance with the facility's policy and procedure (P&P), titled, Safety and Supervision of Residents, This deficient practice placed Resident 1 at risk for fracture on the foot and had the potential to result in reoccurring foot injuries. Findings: During a review of Resident 1's Face Sheet (a document that compiles a resident's information, including name, address, date of birth, insurance details, and emergency contacts as well as medical history, allergies and current medications), the Face Sheet indicated Resident 1 was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included fracture (break in the bone) of metatarsal bones (one or more of the five long bones that connect the ankle to the toes) left foot, Alzheimer's disease unspecified (a disease characterized by a progressive decline in mental abilities, and anxiety (characterized by feelings of worry, apprehension, or nervousness, often accompanied by physical symptoms like increased heart rate or sweating) disorder (fear characterized by behavioral circumstances). During a review of Resident 1's Minimum Data Set (MDS- a Resident assessment tool), dated 1/7/2025, the MDS indicated Resident 1 was assessed having severely impaired cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decision making. Resident 1 was dependent (helper does all of the effort) with toileting hygiene, shower/bathe self, lower body dressing, and putting on/taking off footwear. Resident 1 required substantial/maximal assistance (helper does more than half the effort) with sit to lying, sit to stand, and chair/bed-to chair transfer. (continued on next page)

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 - Few	During a review of Resident 1's care plan titled, Risk for Pathologic Fracture (a bone break that occurs due to a pre-existing disease or condition that has weakened the bone, rather than being caused by a direct injury or trauma), dated 1/15/2025, the care plan indicated Resident 1 was at risk for pathologic/spontaneous fractures (a fracture that occurs in seemingly normal bone without any apparent external force or trauma) related to severe anxiety/agitation (state of anxiety. very worried or upset, and show this in their behavior, movements, or voice) as manifested by (m/b) constant kicking of leg. The care plan's approach/intervention indicated to monitor for signs and symptoms of fractures such as pain, redness, swelling, limitations of range of motion (ROM- measurement of movement around a specific joint or body part). The care plan interventions did not indicate intervention to monitor and or address Resident 1's behavior of constant kicking of leg to prevent fracture. During a review of Resident 1' Progress Note, dated 3/17/2025, at 5:19 PM, the Progress Note indicated Resident 1 with +3 pitting edema (a noticeable deep indentation that takes up to 30 seconds to rebound after pressure is applied to the swollen area) on left foot with bluish skin discoloration, unable to palpate (examine by touch) pedal pulse (the pulse located on the top of the foot used to assess circulation in the lower extremities). The progress notes also indicated Resident 1's Representative (RP) at bedside request for Resident 1 to go to hospital/emergency room (ER) to be evaluated by physician. The progress notes indicated facility staff called and informed physician with order to transfer Resident 1 to GACH ER for evaluation and called ambulance to request for pick. During a review of Resident 1's Computerized Tomography (CT- a medical imaging technique that shows detailed images of any part of the body) of the lower extremity left with contrast dye used to enhance the visibility of certain structures or organs within the body) from General Acute Care Hospital's (GACH), dated 3/18/2025, the CT report indicated Resident 1 had numerous fractures of the left foot including the medial cuneiform (the largest of the three bones in the middle of the foot) and the bases of the 1st and 4th metatarsals (the long bones in the middle of the foot, just below the toes). During a review of the Multi-Disciplinary Report (a document that compiles findings and recommendations from professionals with diverse expertise to address a complex issue or situation), dated 3/18/2025, at 7:10 PM, the Multi-Disciplinary Report indicated Resident 1 has episodes of severe anxiety and agitation, marked by constant kicking of the legs .the kicking could possibly have been caused by contact with the footboard of the bed. During a review of the Facility Reported Incident form, dated 3/21/2025, the Facility Reported Incident form indicated it was determined that the probable cause of numerous toes fractures was most likely the patient's repetitive kicking of the footboard despite the protective barrier that was provided. During an interview on 4/1/2025, at 12:16 PM, with Licensed Vocational Nurse 1 (LVN 1), LVN 1 stated he does not monitor and document Resident 1's behavior of kicking the bed or kicking legs when agitated or anxious in the Treatment Administration Record (TAR- a document used to ensure accurate record-keeping for treatments) and it was not ordered for the resident. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 4/1/2025, at 12:29 PM, with Medical Records Director (MRD), MRD stated Resident 1 was readmitted to the facility from GACH on 3/20/2025 and the resident had a history of behavior of kicking the bed when the resident gets agitated about her gastrostomy (G-tube- surgical opening fitted with a device to allow feedings to be administered directly to the stomach common for people with swallowing problems). MRD stated facility staff does not monitor Resident 1's behavior of kicking the bed and did not have documented evidence the facility staff monitored Resident 1's behavior of kicking when agitated since 1/15/2025 to 3/17/2025 before the reisdent noted to have fracture on the left foot. During an interview on 4/1/2025, at 1 PM with Registered Nurse Supervisor (RNS), RNS stated on 3/17/2025, Resident 1's Responsible Party (RP) informed facility staff there was something wrong with Resident 1's feet. RNS stated Resident 1's feet were assessed and observed to be swollen with the left foot slightly discolored. RNS stated imaging from GACH indicated Resident 1 had a fracture on the resident's left foot. RNS stated she did not know how Resident 1 broke Resident 1'sleft foot. RNS stated Resident 1 had a history of kicking the bed when the resident gets agitated. During an interview on 4/1/2025, at 4:19 PM with the Director of Nursing (DON), the DON stated facility staff was aware of Resident 1's behavior of kicking the bed. The DON stated Resident 1's bed kicking should have been monitored and documented to make sure we are able to address the behavior accordingly/ resident- centered approach to prevent injury/ accident in accordance with the facility's P&P to provide safety, and supervision to prevent accident. . The DON also stated the monitoring and documenting of Resident 1's behavior of kicking the bed should also been added as intervention in the Resident 1's care plan for at risk for pathologic fracture to prevent injury During a review of the facility's policy and procedure (P&P), titled, Safety and Supervision of Residents, revised on 7/2017, the P&P indicated the following: 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. Our individualized, Resident-centered approach to safety addresses safety and accident hazards for individual residents. The care team shall target interventions to reduce individual risks related to hazards in the environment, including adequate supervision and assistive devices.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46919 Based on interview and record review, the facility failed to: 1. Ensure the facility's consultant pharmacist's recommendation for the use of lorazepam (Ativan-an anti-anxiety [characterized by feelings of worry, apprehension, or nervousness, often accompanied by physical symptoms like increased heart rate or sweating] medication) and quetiapine (Seroquel-a psychoactive medication used to treat schizophrenia [a mental disorder characterized by disruptions in thought processes, perceptions, emotional responsiveness and social interactions], bipolar disorder [a mental health condition characterized by extreme shifts in mood ranging from intense highs to periods of intense lows], and depression [low mood, fatigue, and hopelessness]) in the Drug Regimen Review (DRR- a thorough evaluation of the medication regimen of a resident, with the goal of promoting positive outcomes and minimizing consequences and potential risks associated with medication) was communicated to the physician for one of two sampled residents (Resident 1). 2. Ensure the facility's DRR policies and procedures indicated specific method, and time frames the facility will use in order to readily and timely act upon the pharmacist's recommendations for Resident 1. This deficient practice placed Resident 1 at risk of receiving more than the maximum daily allowable dose of Ativan and the unnecessary administration of quetiapine which could lead to adverse consequences (negative or unfavorable outcomes that occur as a result of a specific action, event, or situation) such as drowsiness or unsteadiness which can lead to falls and injuries. Findings: During a review of Resident 1's Face Sheet (a document that compiles a resident's information, including name, address, date of birth, insurance details, and emergency contacts as well as medical history, allergies and current medications), the Face Sheet indicated Resident 1 was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included fracture (fx- a break in the bone) of metatarsal bones (one or more of the five long bones that connect the ankle to the toes) left foot, Alzheimer's disease unspecified (a disease characterized by a progressive decline in mental abilities, and anxiety disorder (fear characterized by behavioral circumstances). During a review of Resident 1's Minimum Data Set (MDS- a Resident assessment tool), dated 1/7/2025, the MDS indicated Resident 1 was assessed having severely impaired cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decision making. The MDS indicated Resident 1 was dependent (helper does all of the effort) with toileting hygiene, shower/bathe self, lower body dressing, and putting on/taking off footwear. The MDS also indicated Resident 1 required substantial/maximal assistance (helper does more than half the effort) with sit to lying, sit to stand, and chair/bed-to chair transfer. Resident 1 was taking antipsychotic (type of drug used to treat symptoms of psychosis) and antianxiety medications. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 1's February 2025 Physician Order Sheet, Resident 1 had a physician order, dated 1/14/2025, for quetiapine 100 milligrams (mg- unit of measurement) 1 tablet via gastrostomy tube (G-tube- a surgical opening fitted with a device to allow feedings to be administered directly to the stomach common for people with swallowing problems) two times daily starting 1/14/2025 for anxiety disorder manifested by (m/b) severe agitation (state of anxiety. very worried or upset, and show this in their behavior, movements, or voice). During a review of Resident 1's February 2025 Physician Order Sheet, Resident 1 had a physician order, dated 1/14/2025, for quetiapine 200 mg 1 tablet via G-tube one time daily starting 1/14/2025 for anxiety disorder. During a review of Resident 1's February 2025 Physician Order Sheet, Resident 1 had a physician order, dated 1/14/2025, for lorazepam 1 mg 1 tablet via G-tube as needed every six hours starting 1/14/2025 for anxiety. The order did not indicate as discontinue/ end date. During a review of Resident 1's March 2025 Physician Order Sheet, Resident 1 had a physician order, dated 2/22/2025, for quetiapine 100 mg 1 tablet via G-tube two times daily starting 2/23/2025 for anxiety disorder m/b severe agitation (order carried over from the previous order from February 2025). During a review of Resident 1's March 2025 Physician Order Sheet, Resident 1 had a physician order, dated 2/22/2025, for quetiapine 200 mg 1 tablet via G-tube one time daily starting 2/23/2025 for anxiety disorder m/b severe agitation (order carried over from the previous order from February 2025). During a review of Resident 1's March 2025 Physician Order Sheet, Resident 1 had a physician order, dated 2/24/2025, for lorazepam 1 mg 1 tablet via G-tube as needed every four hours starting 2/24/2025 for generalized anxiety disorder m/b severe agitation. The order did not indicate as discontinue/ end date (order carried over from the previous order from February 2025). During a concurrent interview and record review, on 4/1/2025, at 3:42 PM, with the Director of Nursing (DON), Resident 1's Consultant Pharmacist's Medication Regimen Review (Drug Regimen Review), dated 2/4/2025 was reviewed. The DON stated Resident 1's DRR indicated the following: Resident 1 is on Ativan 1 mg every (q) six hours as needed (PRN) for anxiety. Per Omnibus Budget Reconciliation Act (OBRA - federal laws passed by Congress aimed at improving quality of care and protected residents' rights in nursing homes) guidelines, the max daily allowable dose for residents > (greater than) [AGE] years old (yo) is 2mg / day. It also indicated the recommendation for Ativan 0.5 mg every 6 hours prn x 14 days and consider a dose decrease and/or adding not more than 2mg/day to the order to prevent dose exceeding allowable limits. Or, provide risk-benefit assessment (a process of comparing the potential benefits of a course of action with the risks involved, to make an informed decision about whether the benefits outweigh the risks) that shows why higher doses are necessary to improve or maintain the resident's functional status. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Receives Seroquel 100 mg twice daily (bid) (AM & PM) and 200 mg at bedtime (hs) for anxiety disorder. Currently, the only acceptable diagnoses for Seroquel in the elderly is 'schizophrenia, depression, or bipolar disorder.' Please consider discontinuing Seroquel and using an alternate medication if warranted. During the same concurrent interview and record review, on 4/1/2025, at 3:42 PM, with the DON, the DON stated there was no written documentation that Resident 1's physician was informed and reviewed the consultant pharmacist's drug recommendations on 2/4/2025. The DON stated the consultant pharmacist's drug recommendations for Resident 1's Ativan and Seroquel were not communicated to Resident 1's physician until 3/30/2025. The DON stated it was her (DON) responsibility to communicate the consultant pharmacist's drug recommendation to the resident's physician. The DON stated the consultant pharmacist's drug recommendations should have been reviewed and relayed to the resident's physician as soon as it was received. The DON stated the facility should not have waited two months to communicate the consultant pharmacist's drug recommendations to the resident's physician. The DON stated it was important to communicate the consultant pharmacist's Ativan recommendation to Resident 1's physician to prevent Resident 1 from receiving more Ativan than legally allowed and to prevent adverse reactions. The DON stated Resident 1 did not have a diagnosis of schizophrenia, depression or bipolar disorder. The DON stated it was important to communicate the consultant pharmacist's Seroquel recommendation to Resident 1's physician to ensure that Resident 1 was ordered the appropriate medication for the appropriate diagnosis for the resident. The DON stated the facility's policy and procedure (P&P) to inform the physician and document were not followed. The DON stated the P&P did not indicate a timeframe on when to act upon the recommendation of the consultant pharmacist. During a review of the facility's P&P titled, Drug Regimen Review (Monthly Report) undated, the P&P indicated the following: Findings and recommendation are reported to the Administrator, Director of Nursing, the attending physician, and the medical director, where appropriate. Resident-specific DRR recommendations and findings are documented and acted upon by the facility licensed personnel and/or physician. During a review of the facility's P&P titled, Medication Therapy, revised on 4/2007, the P&P indicated the medical director and consultant pharmacist shall collaborate to address issues of medication prescribing and monitoring with the practitioners and staff.