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	04/28/2025

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** 48395 Based on interview and record review, the facility failed to provide adequate assistance to prevent accidents for one (1) of two (2) residents (Resident 1). On 4/24/2024, Certified Nursing Assistant 2 (CNA 2) assisted Resident 1 back to bed from the resident's wheelchair without assistance of another facility staff. This failure resulted in Resident 1 having an assisted fall with CNA 2 and placed resident at risk of injury. Findings: During a review of Resident 1's Admission Record, the Admission Record indicated the resident was initially admitted to the facility on [DATE] and readmitted [DATE] with diagnoses of atherosclerotic (a buildup of fats, cholesterol [waxy, fat-like substance found in the blood and cells] and other substances in and on the artery [a blood vessel that carries blood away from the heart and to the body's tissue and organs] walls) heart disease (a group of conditions that affect the heart and blood vessels) and intracranial injury (also known as traumatic brain injury [TBI] is a brain injury caused by external force). During a review of Resident 1's Minimum Data Set (MDS - a resident assessment tool), dated 4/15/2025, the MDS indicated the resident was cognitively intact (ability to think, remember, and reason) with cognitive skills for daily decision making. Resident 1 was dependent (helper does all of the effort. Resident does none of the effort to complete activity or the assistance of 2 or more helpers is required for the resident to complete the activity) with chair/bed-to-chair transfers (the ability to transfer to and form a bed to a chair or wheelchair), going from lying to sitting on the side of the bed, lower body dressing (the ability to dress and undress below the waist), and putting on/taking off footwear. Resident 1 needed substantial/minimal assistance (helper does more than half the effort) with upper body dressing (the ability to dress and undress above the waist and personal hygiene and needed supervision or touching assistance (helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity) with eating. (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 - Few	During a review of Resident 1's Physical Therapy (PT; treatment that helps you improve how your body performs physical movements) Evaluation and Plan of Treatment dated 4/10/2025, the PT Evaluation and Plan of Treatment indicated Resident 1 was referred to PT due to new onset of decrease in strength, decrease in functional mobility, decrease in transfers, reduced balance, and reduced functional activity tolerance which placed Resident 1 at risk for falls, further decline in function, immobility, limited out-of-bed activity, muscle atrophy (wasting), decrease in level of mobility and decreased ability to return to prior level of assistance. The PT Evaluation and Plan of Treatment also indicated Resident 1 informed them that he is non-ambulatory (unable to walk) and is wheelchair bound. the PT Evaluation and Plan of Treatment further indicated under the functional mobility assessment that Resident 1 was dependent with chair/bed-to-chair transfers and under the musculoskeletal (the combination of the muscles and bones of the body, which work together to allow for movement, support, and posture) system assessment Resident 1's fight lower extremity and left lower extremity strength were evaluated to be impaired. During a review of Resident 1's Nursing Daily Note dated 4/24/2025, Resident 1's Nursing Daily Note indicated around 2:00 PM Resident 1 wanted to go back to bed and CNA 2 attempted to assist him back when Resident 1 started to slowly slide down to the floor with CNA 2's assistance and had an assisted fall. The Nursing Daily Note indicated, Resident 1 stated his head came in contact with the floor and resident was transferred to the general acute care hospital (GACH) via (by) 9-1-1 emergency services. During an interview on 4/28/2025 at 2:47 PM with Resident 1, Resident 1 stated on 4/24/2025, he was assisted by CNA 2 from the resident's wheelchair to the bed but the resident fell on the floor and went to GACH. During an interview on 4/28/2025 at 3:14 PM with Registered Nurse (RN), RN stated Resident 1 was transferred to the hospital on 4/24/2025 after having an assisted fall with CNA 2. RN stated CNA 2 was attempting to lift the resident from the resident's wheelchair to the bed and Resident 1 gradually slid down and was assisted to the floor. During an interview on 4/28/2025 at 4:35 PM with the Director or Nursing (DON), the DON stated Resident 1 required 2 person assist and that on 4/24/2025, CNA 2 had told the DON that Resident 1 wanted to go back to bed and CNA 2 did not call for the assistance of a second person to transfer Reisdent1 from wheelchair to the bed. During an interview on 4/28/2025 at 5:37 PM with CNA 2, CNA 2 stated on 4/24/2025 at the start of CNA 2's shift, CNA 2 and the CNA assigned to Resident 1 on 4/24/2025 consulted with Resident 1's usual nurse regarding how to assist Resident 1 to and from bed to wheelchair. CNA 2 stated, CNA 2 and the other CNA were told by the licensed nurse (unable to recall who) that Resident 1 was as 2- person assist. CNA 2 stated later in the day, Resident 1 demanded to go back to bed from his wheelchair and after wheeling Resident 1 back to his bedside, CNA 2 asked Resident 1 to wait so that he could find a second person to assist CNA 2 in transferring Resident 1 back to bed. CNA 2 stated, CNA 2 attempted to lift Resident 1, and the resident was too heavy and started to slide which resulted in CNA 2 holding Resident 1 tightly and sliding him down very slowly to the floor. CNA 2 further stated that CNA 2 should not have lifted or assisted Resident 1 to transfer from wheelchair to bed by himself and should have asked another CNA or licensed nurse to assist. (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 4/28/2025 at 6:18 PM with the DON, the DON stated when a resident who is assessed as a 2-person assist with transfers and is not assisted by 2 people, the resident could potentially fall and could result in an injury to the resident. During a review of the facility's policy and procedure (P&P) titled, Fall Risk Assessment, revised March 2018, the P&P indicated, The nursing staff, in conjunction with the attending physician, consultant pharmacist, therapy staff, and others, will seek to identify and document resident risk factors for falls and establish a resident-centered prevention plan based on relevant assessment information. The P&P further indicated the staff and attending physician will collaborate to identify and address modifiable risk factors and interventions to try and minimize the consequences of risk factors that are not modifiable.

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48395 Based on observation, interview, and record review, the facility failed to ensure one (1) of two (2) sampled residents (Resident 2) received food that accommodated resident intolerances and preferences. This failure placed Resident 2 at risk for experiencing feelings of sadness and distress and had the potential to result in Resident 2 having decreased meal intake which would lead to weight loss and malnutrition (a state of nutritional deficiency or imbalance that occurs when the body does not receive or absorb sufficient nutrients [calories, protein, vitamins, minerals] to maintain health and function properly). Findings: During a review of Resident 2's Admission Record, the Admission Record indicated the resident was initially admitted to the facility on [DATE] and readmitted [DATE] with diagnoses of spondylosis (a condition in which there is abnormal wear on the cartilage [a touch, flexible tissue that lines joints and gives structure to parts of the body] and bones of the neck [cervical vertebrae]) and anxiety disorder (a condition that causes excessive feelings of fear, dread, and uneasiness, along with other symptoms). During a review of Resident 2's Minimum Data Set (MDS - a resident assessment tool), dated 2/1/2025, MDS indicated the resident was cognitively intact (ability to think, remember, and reason) with cognitive skills for daily decision making. Resident 2 was independent (resident completes the activity by themselves with no assistance from a helper) with walking 150 feet, transfers (how resident moves to and from bed, chair, wheelchair, standing position), upper and lower body dressing (the ability to dress and undress above and below the waist), putting on/taking off footwear, personal hygiene and eating. During a review of Resident 2's Physician Order Sheet dated April 2025, the Physician Order Sheet indicated an order from 11/14/2024 for regular diet with a note indicating resident is a vegetarian. During a review of Resident 2's Comprehensive Nutritional assessment dated [DATE], the Comprehensive Nutritional Assessment indicated resident dislikes milk, eggs and meat and her diet order as regular/vegetarian. During a review of Resident 2's Dietary Care Plan dated 5/2025, Resident 2's Dietary Care Plan indicated Resident 2's dietary preference of being vegetarian and indicated interventions including to administer and serve diet as ordered and tolerated and that the dietary supervisor will adhere to resident's food preferences. (continued on next page)

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 2's Daily Nursing Note dated 4/14/2025, the Daily Nursing Note indicated Resident 2 was upset due to receiving a lunch tray where beef was mixed in with her food and she is vegetarian. The Daily Nursing Note also indicated that the resident's food tray was checked, and a tiny piece of meat was found in the middle of the scoop of rice and that the cook in the kitchen was aware that the resident is vegetarian. The Daily Nursing Note further indicated resident had thrown up twice due to the incident and had complained that she had not had meat in over [AGE] years. During a review of Resident 2's Daily Nursing Note dated 4/26/2025, the Daily Nursing Note indicated that during dinner time around 5:50 PM, resident found two pieces of chicken in her soup which was witnessed by Licensed Vocational Nurse 1 (LVN 1). During an interview on 4/28/2025 at 2:20 PM with the Administrator (ADM), the Administrator stated on 4/26/2025 Resident 2 was served chicken in her soup against her religious and personal preference. The ADM stated all staff are aware that Resident 2 is a vegetarian and that Resident 2's dietary preference is reflected in her meal tickets. During a concurrent observation and interview on 4/28/2025 at 3:20 PM with Resident 2 inside her room, two small pieces of chicken were observed on top of a small soup lid. Resident 2 stated she kept the two small pieces of chicken that were found in her soup from 4/26/2025 as evidence. Resident 2 stated, on 4/26/2025 around 5:00 PM for dinner, she found 2 small pieces of chicken in her soup and stated it was not the first time and during a previous incident she had found ground beef in her rice. Resident 2 also stated that it is a sin (an action or thought that goes against moral or religious standards) in her religion to eat meat and it made her sad and disturbed when she found out that she sinned. During an interview on 4/28/2025 at 3:53 PM with Certified Nursing Assistant 1 (CNA 1), CNA 1 stated on 4/26/2025 she was called by Resident 2 to her room and observed two small pieces of chicken in Resident 2's soup. During an interview on 4/28/2025 at 3:56 PM with LVN 1, LVN 1 stated on 4/26/2025 she was called over to Resident 2's room and was a witness to Resident 2 finding chicken in her soup. LVN 1 stated Resident 2's soup container was open and on top of the lid she observed 2 pieces of chicken that Resident 2 had found in her soup. During an interview on 4/28/2025 at 4:35 PM with the Director of Nursing (DON), the DON stated upon a resident's admission, the dietary supervisor assesses the resident's food preferences. The DON stated that Resident 2 has been a vegetarian since her admission to the facility and it is the kitchen's responsibility to ensure the resident's food is prepared and correctly matches the resident's preferences & meal ticket. The DON also stated there is another meal tray check on the floor by the CNAs prior to the meal trays being distributed out to the residents, however, upon the CNA meal tray check they are unable to individually scoop through the food on the tray to check those items and the last two incidents where Resident 2 found meat in her food were only found after Resident 2 had started going through her food. (continued on next page)

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 4/28/2025 at 6:05 PM with the [NAME] (CK), the CK stated in the kitchen during trayline (a system used in food service where food trays are moved along an assembly line) the trayliner (person who reads out resident's meal ticket preferences to cook) reads out the resident's meal ticket to the cook who then places the corresponding food onto the resident's plate. The CK stated, at least three people in the kitchen double check the meal trays prior to it being delivered to the floor, however, there may sometimes be a mistake. The CK further stated if ever a resident does not get their food preference it can result in them getting upset and mad. During an interview on 4/28/2025 at 6:15 PM with the DON, the DON stated when a resident doesn't receive their food preference it can end up affecting their physical, emotional and mental wellbeing. During a review of the facility's policy and procedure (P&P) titled, Resident Food Preferences revised July 2017, the P&P indicated, Individual food preferences will be assessed upon admission and communicated to the interdisciplinary team. During a review of the facility's P&P titled, Accommodation of Needs, revised March 2021, the P&P indicated, The resident's individual needs and preferences are accommodated to the extent possible, except when the health and safety of the individual or other residents would be endangered.