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	05/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Gem Tcu	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 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** Based on observation, interview, and record review, facility staff failed to revise the care plan (a dynamic, written document outlining a patient's health needs, goals, and customized interventions, formulated through assessment) for the use of mechanical lift (a device used to safely transfer individuals with limited mobility between beds, wheelchairs, and chairs, reducing physical strain on caregivers) for one of two (2) sampled residents (Resident 1) as indicated on the facility policy. This deficient practice had the potential for Resident 1 not to receive resident specific interventions to ensure safety.Findings:During a review of Resident 1's admission Record, the admission Record indicated Resident 1 was initially admitted to the facility on [DATE] and re-admitted to the facility on [DATE]. Resident 1's diagnoses included hemiplegia (a severe or complete loss of strength or paralysis on one side of the body) and hemiparesis (a mild loss of strength in a leg, arm, or face) following cerebral infarction (a damage to tissues in the brain due to a loss of oxygen to the area) affecting right dominant side, hydrocephalus unspecified (water in the brain, an abnormal buildup of cerebrospinal fluid [a clear, colorless liquid produced in the brain] in the brain's ventricles without a specified cause), and Guillain-Barre syndrome (a rare neurological disorder in which a person's immune system mistakenly attacks part of the network of nerves that carries signals from the brain and spinal cord to the rest of the body). During a review of Resident 1's MDS dated [DATE], the MDS indicated Resident 1 was severely impaired with 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, resident does none of the effort to complete the activity) with eating, oral hygiene, toileting hygiene, shower/ bathe self, upper and lower body dressing, putting on/ taking off footwear, personal hygiene, and sit to lying. During a concurrent observation and interview on 5/4/2026 at 10:16 AM with Certified Nursing Assistant 1 (CNA 1) inside Resident 1's room, observed Resident 1 being transferred from the shower chair back to the resident's bed by CNA 1 and CNA 2. CNA 1 stated since Resident 1 was light weight, the resident can be transferred with two people assistance. CNA 1 and CNA2 stated they have always used two people assist to transfer Resident 1 and have never used a mechanical lift. During a review of Resident 1's comprehensive admission MDS, dated [DATE], the MDS indicated mechanical lift was one of the devices and aids used for the resident. During a review of Resident 1's Care Plan, dated 8/9/2025, the Care Plan indicated intervention for Resident 1's precaution for further falls and injuries was the use of assistive devices such as wheelchair and mechanical lift. During a concurrent interview and record review on 5/5/2026 at 9:55 AM with MDS nurse, Resident 1's Care Plan Report dated 8/9/2025 to 5/4/2026, and the MDS assessment dated [DATE] were reviewed. MDS nurse stated she was not aware that the nursing staff did not use mechanical lift to transfer Resident 1 but instead utilized two people to assist with the resident's transfer. MDS nurse stated she should have reviewed and revised Resident 1's care plans after each MDS assessment was completed to keep the resident's care plan current and updated. During a review of the facility's Policy and Procedure (P&P) titled, Care Plans, Comprehensive Person-Centered, dated 2001, the P&P indicated a comprehensive, person-centered (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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident.Assessments of residents are ongoing, and care plans are revised as information about the residents and the residents' conditions change. The interdisciplinary team reviews and updates the care plan: when the desired outcome is not met;when the resident has been readmitted to the facility from a hospital stay; andat least quarterly, in conjunction with the required quarterly MDS assessment.

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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 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** Based on observation, interview, and record review, facility staff failed to develop and implement a care plan for proper safety precautions for one (1) of two (2) sampled Residents (Resident 1) by failing to identify interventions related to the resident's specific risks which included behavior of kicking his legs while in bed. This deficient practice resulted to Resident 1 sliding off from the bed on 3/24/2026 and potential for further falls which could cause injury and harm to the resident. Findings: During a review of Resident 1's admission Record, the admission Record indicated Resident 1 was initially admitted to the facility on [DATE] and re-admitted to the facility on [DATE]. Resident 1's diagnoses included hemiplegia (a severe or complete loss of strength or paralysis on one side of the body) and hemiparesis (a mild loss of strength in a leg, arm, or face) following cerebral infarction (a damage to tissues in the brain due to a loss of oxygen to the area) affecting right dominant side, hydrocephalus unspecified (water in the brain, an abnormal buildup of cerebrospinal fluid [a clear, colorless liquid produced in the brain] in the brain's ventricles without a specified cause), and Guillain-Barre syndrome (a rare neurological disorder in which a person's immune system mistakenly attacks part of the network of nerves that carries signals from the brain and spinal cord to the rest of the body). During a review of Resident 1's Minimum Data Set (MDS, resident assessment tool), dated 1/23/2026, the MDS indicated Resident 1 was severely impaired with 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, resident does none of the effort to complete the activity) with eating, oral hygiene, toileting hygiene, shower/ bathe self, upper and lower body dressing, putting on/ taking off footwear, personal hygiene, and sit to lying. The MDS also indicated Resident 1 did not have any fall episodes. During a review of Resident 1's Situation, Background, Assessment, and Recommendation communication form (SBAR, a structured framework used in healthcare to ensure concise and effective communication during critical situations, patient handoffs, or provider calls), dated 3/24/2026, the SBAR communication form indicated Resident 1 slid off the bed, slowly down to the floor mat. During a concurrent interview and record review on 5/4/2026 at 2:55 PM with Registered Nurse Supervisor (RNS), Resident 1's SBAR communication form dated 3/24/2026 was reviewed. RNS stated Resident 1 slid off the bed unto the floor mat. RNS stated she was not aware how Resident 1 slid off the bed. During an observation on 5/4/2026 at 9:45 AM in Resident 1's room, Resident 1 was awake lying on a low air loss mattress (a special mattress that gently blows air through small holes to help keep the skin dry and reduce pressure, which helps prevent or treat pressure injuries). Resident 1 was unable to speak. Resident 1 had bilateral upper quarter side rails (a safety bar attached to the side of a bed to help prevent a person from falling out and to provide support when moving or repositioning) up. During an interview on 5/5/2026 at 10:16 AM with Certified Nursing Assistant 3 (CNA 3), CNA 3 stated she placed Resident 1 back to his bed after returning from the shower room. CNA 3 stated she raised Resident 1's bilateral side rails. CNA 3 stated she went outside of the resident's room to obtain linen from the linen cart, which was located in front of Resident 1's room. CNA 3 stated by the time she returned to the resident's room, Resident 1 was observed sitting on the floormat with his back against the bed frame. CNA 3 stated Resident 1 tends to kick a lot when in bed, which could contribute to resident falling. CNA 3 stated Resident 1 was kicking a lot during activities of daily living (ADL) care on 3/24/26, and stated she should have stayed with Resident 1 to prevent him from sliding off his bed. During a concurrent interview and record review on 5/5/2026 at 11:33 AM with the Director of Nursing (DON), Resident 1's care plan (a dynamic, written document outlining a patient's health needs, goals, and customized interventions, formulated through assessment), dated 3/24/2026 was reviewed. The DON stated Resident 1's care plan did not include resident - centered safety protocols to prevent falls. The DON also stated (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident 1's care plan did not, but should have, addressed Resident 1's behavior of kicking his legs which could result in sliding off the bed. The DON stated Resident 1 had another fall in 11/2025 which resulted from this same behavior. The DON stated CNA 3 should have stayed inside the room with Resident 1 to prevent him from sliding off the bed. The DON also stated it is very important to prevent Resident 1 from further falls to avoid severe injuries like hip fractures (a break in the upper part of the thigh bone [femur] near the hip joint, which usually happens from a fall and often requires medical treatment). During a review of the facility's Policy and Procedure (P&P) titled, Falls and Fall Risk, Managing, dated 2001, the P&P indicated based on previous evaluations and current data, the staff will identify interventions related to the resident's specific risks and causes to try to prevent the resident from falling and to try to minimize complications from falling. The P&P also indicated that according to the MDS, a fall is defined as: Unintentionally coming to rest on the ground, floor or other lower level, but not as a result of an overwhelming external force (e.g., a resident pushes another resident). The P&P also indicated Resident-Centered Approaches to Managing Falls and Fall RiskThe staff, with the input of the attending physician, will implement a resident-centered fall prevention plan to reduce the specific risk factor(s) of falls for each resident at risk or with a history of falls.If falling recurs despite initial interventions, staff will implement additional or different interventions or indicate why the current approach remains relevant. During a review of the facility's P&P titled, Care Plans, Comprehensive Person-Centered, dated 2001, was reviewed. The P&P indicated:Care plan interventions are chosen only after data gathering, proper sequencing of events, careful consideration of the relationship between the resident's problem areas and their causes, and relevant clinical decision making. When possible, interventions address the underlying source(s) of the problem area(s), not just symptoms or triggers.