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	05/06/2026

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 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that a working call system is available in each resident's bathroom and bathing area. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide a functional call light for two (2) of three (3) sampled residents (Residents 2 and 3) in accordance with the facility's policy and procedure (P&P) titled Call System (an emergency, nurse, or service-oriented communication setup that allows users to push a button to alert staff or caregivers), Resident. These failures had the potential to put Residents 2 and 3 at risk of experiencing delays in receiving assistance from facility staff, which could lead to an accident or injury.Findings: 1.During a review of Resident 2 's admission Record, it indicated, the resident was initially admitted to the facility on [DATE] with diagnoses of type 2 diabetes mellitus (a disease that occurs when there is a problem in the way the body regulates and uses sugar as fuel), muscle weakness , and urinary tract infection (UTI, an infection of the bladder and urinary system) and urinary retention (a condition that makes it difficult to empty the bladder, either partially or completely) . During a review of Resident 2 's Minimum Data Set (MDS - a resident assessment tool), dated 4/19/2026, the MDS indicated that the resident had moderately impaired cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decision making. The MDS indicated Resident 2 required supervision or touching assistance (helper provides verbal cues and/or touching or steadying as the resident completes the activity) for personal hygiene (the ability to maintain personal hygiene, including combing hair, shaving, applying makeup, washing, and drying face and hands). It also indicated, substantial maximal assistance (helper does more than half the effort) was needed for sit-to-stand (the ability to come to a standing position from sitting in a chair). During a review of Resident 2's care plan initiated on 4/19/2026, the care plan indicated that Resident 2 requires the use of bilateral one-fourth (1/4) partial side rails (a pair of short safety rails, one on each side, attached to the upper section of a hospital or care bed, spanning only about a quarter of the bed's total length) as an enabler. The care plan also the intervention was to place the call light and frequently used items within reach and to answer the call light promptly. 2. During a review of Resident 3's admission Record, the admission Record indicated the resident was initially admitted to the facility on [DATE] with diagnoses of muscle weakness, cirrhosis (a condition in which the liver is scarred and permanently damaged) and dysphagia (difficulty swallowing). During a review of Resident 3 's MDS, dated [DATE], the MDS indicated that the resident had moderately impaired cognitive skills for daily decision making. Resident 3 required supervision or touching assistance for personal hygiene. It also indicated Resident 3 was dependent (helper does all the effort) for chair-to-bed transfer and tub/shower transfer (the ability to get in and out of a tub or shower). During a review of Resident 3's care plan initiated on 12/24/2026, the care plan indicated Resident 3 requires the use of bilateral one-half (1/2) side rails The care plan also indicated that Resident 3 was at risk for entrapment or injury. the intervention was to place the call light and frequently used items within reach and to answer the call light promptly. During an observation on 5/6/2026 at 6:40 AM at Nursing Station A, the call light the indicator light for Room A was on from the call light indicator panel/ board (panel with resident's room number and light indicator if the call light was switched on), there was no sound heard. Certified Nursing Assistant (CNA 1) was observed standing at the nursing station counter checking a folder, and a Licensed (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Vocational Nurse (LVN 1) was sitting in front of the computer. Room A's call light indicator by the door was also visibly lit from Nursing Station A. During an interview on 5/6/2026 at 6:45 AM in Room A with CNA 1, CNA 1 stated, When the call light is on, we need to come right away to attend to residents' needs. During an interview on 5/6/2026 at 6:46 AM with Resident 3 in Room A, Resident 3 stated staff do not answer the call light and that it took one hour or more for the call light to be answered. Resident 3 also stated sometimes he had to bang the grabber on the table for staff to come. During an interview on 5/6/2026 at 6:48 AM with Resident 2 in Room A, Resident 2 stated it took one hour or more for staff to answer the call light, and that this happened all the time. During a concurrent observation and interview on 5/6/2026 at 7AM with the Director of Nursing (DON), the DON pressed the call light in Room A for Resident 2 and 3. The DON stated that the call light outside Room A's door for Resident 2 and 3 at Nursing Station A was lit; however, it did not make an alert sound. During an interview on 5/6/2026 at 7:09 AM with the Licensed Vocational Nurse (LVN 1), LVN 1 stated the call lights were answered as soon as possible to attend to residents' needs. LVN 1 also stated the call light in Room A does not have sound when pressed. During an interview on 5/6/2026 at 11:47 AM with LVN 2, LVN 2 stated the call light board located in the nursing station does not have sound, only light. LVN 2 stated the call light was broken because there should be sound to alert the nurses at the station. The call light is a means of resident communication and needs to be answered as soon as possible. During a concurrent interview and record review on 5/6/2026 at 11:48 AM with LVN 2, the facility's P&P titled Call System, Resident, revised date 9/2022, was reviewed. LVN 2 stated the P&P indicated residents are provided with a means to call staff for assistance through a communication system that directly calls a staff member or a centralized workstation. LVN 2 also stated the P&P indicated the call system remains functional at all times and if audible communication is used, the volume is maintained at an audible level that can easily be heard. LVN 2 also stated that calls for assistance are answered as soon as possible. LVN 2 also stated that the P&P for Call System, Resident was not followed. During a concurrent interview and record review on 5/6/2027 at 12:55 PM with LVN 3, the facility's P&P titled Care Plans, Comprehensive Person Centered, dated 2001, was reviewed. LVN 3 stated the P&P indicated that a comprehensive, person-centered care plan including measurable objectives and a timetable to meet the resident's physical, psychosocial (how a person feels emotionally and how they interact with other people), and functional needs is developed and implemented for each resident. LVN 3 stated the care plan for Resident 2 and 3 was not implemented and that the P&P for care plan was not followed since Resident 2 and 3's call light were not answered promptly.