STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055464	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Two Palms Care Center	2637 E. Washinton Blvd Pasadena, CA 91107

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40037 Based on observation, interview, and record review the facility failed to ensure two (2) of three sampled residents (Resident 41 and Resident 23) for the dignity care area, were not provided with dignity and privacy by failing to: a. Assist Resident 41 at eye level during meal. b. Ensure Resident 23's whole body was not exposed during a bed bath by covering the body part not being washed at a time. These failures have the potential to affect Residents 41 and 23's residents' emotional and mental well-being. Findings: a. A review of Resident 41's Admission Record indicated Resident 41 was readmitted to the facility on [DATE], with diagnoses that included hypertensive heart disease (heart disease caused by high blood pressure) and type 2 diabetes mellitus (a disease that occurs when blood sugar is too high). A review of Resident 41's Minimum Data Set (MDS, a resident assessment and screening tool), dated 3/5/2024, indicated Resident 41 had clear speech, understood others and made self-understood. Resident 41 required partial/moderate assistance (helper does less than half the effort) for eating and substantial/maximal assistance (helper does more than half the effort) for oral hygiene, upper body dressing and personal hygiene. During an observation on 3/30/2024 at 5:25 pm, in Resident 41's room, Resident 41 was in bed sitting up with dinner tray on bedside table across the resident's bed. Certified Nursing Assistant 2 (CNA2) was standing next to Resident 41's bed assisting Resident 41 with dinner. During an interview on 3/30/2024 at 5:35 pm, CNA2 stated CNA2 should sit down at eye level of Resident 41 when assisting Resident 41's meal. CNA2 stated that was to maintain Resident 41's dignity and respect Resident 41's right. (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: 055464	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/31/2024
NAME OF PROVIDER OR SUPPLIER Two Palms Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 2637 E. Washinton Blvd Pasadena, CA 91107	

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 2/9/2024 at 7:22 pm, CNA1 stated CNA1 should sit down at eye level of Resident 41 when assisting Resident 41's meal. CNA1 stated that was to maintain Resident 41's right to be treated with dignity and respect During an interview on 3/31/2024 at 3:07 pm, Infection Prevention Nurse (IPN) stated the facility staff should sit down at eye level of the residents when assisting meal for resident's dignity, respect, and make resident feel home like. During a review of the facility's policy and procedure titled, Privacy and Dignity, revised 6/1/2017, indicated, The facility promotes resident care in a manner and an environment that maintains or enhances dignity and respect, in full recognition of each resident's individuality. The facility promotes independence and dignity in dining. 40913 b. A review of Resident 23's Admission Record indicated the facility readmitted the resident on 2/22/2024, with diagnoses that included paraplegia (impairment in motor or sensory function of the lower extremities) and contracture (shortening and hardening of muscles, tendons, or other tissue, often leading to deformity and rigidity of joints) of bilateral elbows and knees. A review of Resident 23's MDS, dated [DATE], indicated the resident was rarely able to express ideas and wants and was rarely able to understand verbal content. The MDS indicated Resident 23 was dependent with all activities of daily living. During an observation on 3/30/2024 at 9:36 am to 9:40 am, Certified Nursing Assistant 3 (CNA 3) removed Resident 23's clothes. Resident 23's body was not covered while CNA 3 washed the resident's face, neck, and upper body and poured water on the perineal area, then CNA 3 moved down the legs. During an observation on 3/30/2024 at 9:40 am to 9:48 am, Resident 23's body was not covered while CNA 3 was drying Resident 23's front with a towel. CNA 3 then washed Resident 23's back while the resident whole body was exposed. CNA 3 applied lotion then started to put Resident 23's clothes on. During an interview on 3/31/2024 at 9:41 am, CNA 3 stated she should have covered Resident 23 during bed bath. During an interview on 3/31/24 at 10:11 am, the Director of Staff Development (DSD) stated it was important to keep residents covered up and uncover by body part during a bed bath so Resident 23 would not feel exposed and the resident could lose self-respect. During a review of the facility's Policy and Procedure titled, Bed Baths, dated June 1, 2017, indicated the following procedure for providing a bed bath .Without exposing the resident, remove the top sheet form underneath the bath blanket .Place a bath towel over the resident's chest. Fold the top of the bath blanket down to the abdomen then raise the bath towel and wash the resident's chest. Cover the resident's entire chest area with a bath towel. Fold the bath blanket down to the resident's pubic area. Wash the resident's abdomen. Rinse well and dry the abdomen. Pull the bath blanket back above the abdomen and chest. Washing the Lower Body, begin with the resident's leg farthest from you. Pull the far, lower corner of the bath blanket toward you, exposing only the one leg . (continued on next page)

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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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility's Policy and Procedure titled, Privacy and Dignity, dated June 1, 2017, indicated the facility promotes resident care in a manner and an environment that maintains or enhances dignity and respect, in full recognition of each resident's individuality.

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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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40037 Based on observation, interview and record review, the facility failed to ensure the call light (an alerting device for nurses or other nursing personnel to assist a resident when in need) within reach for two of 17 sampled residents (Resident 15 and Resident 17). This failure had the potential to result in Residents 15 and 17 not receiving assistance in a timely manner. Findings: a. A review of Resident 15's Admission Record indicated Resident 15 was admitted on [DATE], with diagnoses that included difficulty walking, dysphagia (difficult swallowing) and depression (a constant feeling of sadness and loss of interest, which stops you doing your normal activities). A review of Resident 15's Minimum Data Set (MDS, a standardized assessment and care planning tool), dated 3/1/2024, indicated Resident 15 had clear speech, had ability to express ideas and wants and had ability to understand others. Resident 15 had intact cognitive skills for daily decision making. Resident 15 required substantial/maximal assistance (helper does more than half the effort, helper lifts or holds trunk or limbs and provides more than half the effort) for chair/bed-to-chair transfer, toilet hygiene, and was partial/moderate assistance (helper does less than half the effort.) for upper body dressing and personal hygiene). During an observation and concurrent interview with Infection Preventionist Nurse (IPN) on 3/29/2024 at 6:40 pm, in Resident 15's room, Resident 15 was sitting in wheelchair away from Resident 15's bed watching TV. Resident 15's call light handler was under Resident 15's bed on the floor. Resident 15 stated Resident 15 could not reach the call light from where Resident 15 sat. IPN stated Resident 15's call light was under Resident 15's bed, and Resident 15 was not able to reach it. IPN stated Resident 15 could fall causing injury if Resident 15 trying to reach call light when need help. Resident 15 stated the call light should place within reach of the resident to prevent accident. 42781 b. A review of Resident 17's Admission Record indicated the facility admitted Resident 17 on 12/20/2023 with diagnoses that included history of falling and chronic obstructive pulmonary disease (COPD - type of obstructive lung disease characterized by long-term poor airflow). A review of Resident 17's Fall Risk Assessment (method of assessing a patient's likelihood of falling), dated 3/7/2024, indicated Resident 17 was assessed as at high risk for fall. A review of Resident 17's Care Plan, dated 10/19/2023, indicated Resident 17 was at risk for fall related to balance problems The Care Plan interventions indicated for the nursing staff to place Resident 17's call light within reach and to encourage Resident 17 to use the call light for assistance as needed. The CP indicated Resident 17 needed a prompt response to all requests from the nursing staff. (continued on next page)

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Two Palms Care Center	2637 E. Washinton Blvd Pasadena, CA 91107

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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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident 17's MDS, dated [DATE], indicated Resident 17 's cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decision making was severely impaired. The MDS indicated, Resident 17 required moderate assistance with shower and lower body dressing. The MDS indicated, Resident 17 was dependent to staff during toileting hygiene. During a concurrent observation on 3/29/2024 at 6:36 pm, Resident 17 was asleep, lying in bed with call light hanging at the upper right side of Resident 17's bed. During a concurrent observation and interview on 3/29/2024 at 6:36 pm, with Licensed Vocational Nurse 1 (LVN 1), the LVN 1 stated Resident 17's call light was hanging on the upper right side of the bed. LVN 1 stated Resident 17's call light was not within the resident's reach. LVN 1 stated Resident 17 was unable to reach the call light. LVN stated, call light was needed to be within reach for Resident 17 to use if she needed assistance. LVN 1 stated, Resident 17 had history of fall and ensuring the call light was within the resident's reach can avoid accidents or injury . During an interview on 3/30/2024 at 4:19 pm, with the Director of Nursing he (DON), DON stated, call light was needed to be within the resident's reach for the staff to attend to Resident 17's needs in a timely manner. The DON stated, call light should be within reach for Resident 17 to easily call for help and to maintain Resident 1's safety. A record review of the facility's policy and procedure (P&P) titled, Communication- Call System, revised on 10/24/2022, indicated call cords will be placed within the resident's reach in the resident's room.

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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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40037 Based on interview and record review, the facility failed to follow its policy on Advance Directives (AD, legal documents that provide instructions for medical care and only go into effect if resident cannot communicate his/her own wishes) to three of four sampled residents (Resident 15, Resident 17 and Resident 29) for Advance Directive care area by failing to: 1. Provide information to Resident 15 regarding AD and right to formulate an AD. 2. Ensure Resident 17 and 29's Advance Directive was placed in the residents' medical record. These failures have the potential to not provide option to Residents 15, 17, and 29 to be able to exercise their right to formulate an advanced directive, which could result into conflict in carrying out the residents' wishes for medical treatment and health care decisions. Findings a. A review of Resident 15's Admission Record indicated Resident 15 was admitted on [DATE], with diagnoses that included difficulty walking, dysphagia (difficult swallowing) and depression (a constant feeling of sadness and loss of interest, which stops you doing your normal activities). A review of Resident 15's Minimum Data Set (MDS, a resident assessment and care screening tool) dated 3/1/2024, indicated, Resident 15 had clear speech, had ability to express ideas and wants and had ability to understand others. Resident 15 had intact cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decision making. Resident 15 required substantial/maximal assistance (helper does more than half the effort, helper lifts or holds trunk or limbs and provides more than half the effort) for chair/bed-to-chair transfer, toilet hygiene, and was partial/moderate assistance (helper does less than half the effort.) for upper body dressing and personal hygiene). A concurrent record review of Resident 15's medical record (MR) and interview with the Director of Nursing (DON) on 3/20/2024 at 10:57 am, the DON stated Resident 15's MR indicated there was no AD screening for Resident 15. The DON stated the AD screening should be provided to resident upon admission to provide the resident information on AD and to know their treatment preferences. The DON stated it was important to know their treatment options so the facility would not treat the resident against their will. b. A review of Resident 17's Admission Record indicated the facility admitted Resident 17 on 12/20/2023 with diagnoses that included history of falling and Chronic Obstructive Pulmonary Disease (COPD - type of obstructive lung disease characterized by long-term poor airflow). A review of Resident 17's MDS, dated [DATE], indicated, Resident 17 's cognitive skills for daily decision making was severely impaired. The MDS indicated, Resident 17 required moderate assistance with shower and lower body dressing. The MDS indicated, Resident 17 was dependent to staff during toileting hygiene. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of Resident 17's Advance Directive Acknowledgement Form, dated 10/23/2023, indicated Resident 17 had Advance Directive executed. During an interview on 3/30/2024 at 11:19 am, Medical Records Director (MRD) stated, she was unable to find Resident 17's AD in the chart. The MRD stated, AD should be in Resident 17's clinical records to access immediately in case of emergency. 42781 c. A review of Resident 29's Admission Record indicated the facility admitted Resident 29 on 3/26/2023 with diagnoses that included encounter for attention to gastrostomy (creation of an artificial external opening into the stomach for nutritional support) and dementia (long term and often gradual decrease in the ability to think and remember severe enough to affect a person's daily functioning). A review of Resident 29's History and Physical (H&P), dated 3/29/2023, indicated Resident 29 did not have the capacity to understand and make decisions. A review of Resident 29's MDS, dated [DATE], indicated Resident 29 's cognitive skills for daily decision making was severely impaired. The MDS indicated Resident 29 was dependent to staff with oral hygiene, toileting, shower and personal hygiene. A review of Resident 29's Advance Directive Acknowledgement Form, dated 4/1/2023, indicated Resident 29 had executed an AD. During an interview on 3/30/2024 at 11:34 am, MRD stated, she was unable to find Resident 29's AD in the chart. The MRD stated, AD should be in Resident 29's clinical records to access immediately in case of emergency. The MRD stated, the form should be filled up completely. During an interview on 3/30/2024 at 4:23 pm, with the facility's Director of Nursing (DON), the DON stated AD should be in the chart to retrieve easily and staff to have easy access. A review of the facility's Policy and Procedure titled, Advance Directives, revised 6/2021, indicated upon admission, Admission staff or designee will inform the resident of their right to execute an Advance Directive Form, if one does not already exist. The P&P indicated, if the resident has an Advance Directive, Admission Staff or designee will place a copy of the Advance Directive in the resident's medical record and will notify the Director of Social Services of the existence of the Advance Directive. The P&P indicated if the resident chooses to execute an Advance Directive, the Director of Social Services or his or her designee will contact the Ombudsman so that the Ombudsman can witness the resident signing the Advance Directive.

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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 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted 40913 Based on observation, interview, and record review, the facility failed to develop a baseline care plan for one of 17 Residents (Resident 37) who was at risk for developing a pressure ulcer (wound that occurs as a result of prolonged pressure on a specific area of the body)) and had undergone surgical procedure for a pressure ulcer. This deficient practice had the potential for Resident 37 to not be provided with interventions to prevent the development of a pressure ulcer and worsening of surgical wound. Findings: A review of Resident 37's Admission Record indicated the facility initially admitted the resident on 8/20/2023 and readmitted the resident on 2/21/2024, with diagnoses that included type 2 diabetes (a disease in which the body's ability to produce or respond to the hormone insulin is impaired, resulting in elevated levels of glucose/sugar in the blood and urine,) cervical disc disorder at C5-C6 level with radiculopathy (pinched nerve that causes pain, weakness, numbness.) A review of Resident 37's Minimum Data Set (MDS, a standardized assessment and care planning tool), dated 3/6/2024, indicated the resident was rarely able to express ideas and wants and was rarely able to understand verbal content. During an observation on 3/31/24 at 8:25 am, Certified Nursing Assistant 1 (CNA 1) was providing incontinent care to Resident 37. There was an intact dressing to the sacral coccyx area. During a concurrent record review and interview with the Assistant Director of Nursing (ADON) on 3/31/2024 at 1:40 pm, the ADON stated there was no care plan for altered skin integrity or a care plan for the pressure ulcer on readmission on 2/21/2024. The following care plans for Resident 37 were initiated on 3/6/2024 and on 3/8/2024; a. Potential for pressure ulcer development related to history of ulcers and to immobility was initiated on 3/6/2024 b. Actual impairment to skin integrity of the sacral coccyx related to surgical wound dehiscence was initiated on 3/8/2024. During an interview on 3/31/2024 at 2:46 pm, the Director of Nursing (DON) stated the facility did not and should have developed a care plan specific to Resident 37's pressure ulcer upon admission on 2/21/2024. The DON stated, If we had developed the care plan on the actual pressure ulcer, we could add interventions such as turning and repositioning, encouraging resident to eat, make sure to keep resident clean and dry, limit the time on the wheelchair because the Resident's family would always want her on the wheelchair even after she came back from the hospital. (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the Wound Consultant progress notes dated 2/29/2024, indicated Resident 37 returned from the hospital on 2/21/2024 where a procedure was performed to close the sacral wound with sutures.

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide activities to meet all resident's needs.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 40913

Based on observation, interview, and record review, the facility failed to provide an activity based on resident's preference and activity assessment for two of three sampled residents (Resident 7 and 40) from Activity care area.

This deficient practice had the potential not to meet Residents 7 and 40's interests and activity needs, which could affect the physical, mental, and psychosocial well-being of each resident.

Findings:

a. A review of Resident 7's Admission Record indicated the facility readmitted the resident on 1/8/2024 with diagnoses that included metabolic encephalopathy (a problem in the brain caused by a chemical imbalance in the blood) and bipolar disorder (mental disorder with periods of depression and periods of elevated mood.

A review of Resident 7's Minimum Data Set (MDS, a standardized assessment and care planning tool), dated 12/21/2024, indicated Resident 7 was rarely able to express ideas and wants and was rarely able to understand verbal content. The MDS indicated Resident 7 was dependent with toileting and required moderate assistance (helper does less than half the effort) with rolling left and right.

A review of Resident 7's Activity Quarterly Assessment, dated 3/30/2024, indicated Resident 7 usually preferred to stay in the room to watch TV, play ballgames, and hand spa.

During a concurrent record review and interview with the Activities Director (AD) on 3/31/2024 at 4 pm, AD stated Resident 7's Attendance Record for Activities, dated March 2024, indicated there were 5 consecutive days from 3/21/2024 to 3/25/2024 that were blank. The AD stated Resident 7 preferred room activities. The AD stated there were daily group activities, but sometimes the AD did not have enough time for room activities.

b. A review of Resident 40's Admission Record indicated the facility admitted the resident on 9/20/2023, with diagnoses that included Alzheimer's disease (irreversible, progressive brain disorder that slowly destroys memory and thinking skills, and eventually the ability to carry out the simplest tasks) and anxiety disorder (group of mental disorders characterized by feelings of anxiety [an unpleasant state of inner turmoil] and fear.
)

A review of Resident 40's MDS, dated [DATE], indicated Resident 40 sometimes was able to express ideas and wants and sometimes able to understand verbal content. The MDS indicated Resident 40 required maximal assistance (helper does more than half the effort) with rolling left to right and dependent with lying to sitting mobility.

A review of Resident 40's Activity Initial assessment dated [DATE], indicated Resident 40's activities, interests, and hobbies included TV/radio, hand spa, ballgames, coffee, snacks.

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent record review and interview with the AD on 3/31/2024 at 3:53 pm, AD stated Resident 40's Attendance Record for Activities dated March 2024, indicated there were 5 consecutive days from 3/7/2024 to 3/11/2024 that were blank. The AD stated there were days when she was unable to provide daily in-room activities for those residents who stayed in their rooms. During a review of the facility's Policy and Procedure titled, Activities Program, revised 4/1/2021, indicated to encourage residents to participate in activities to make life more meaningful. To stimulate and support physical and mental capabilities to the fullest extent, and to enable the resident to maintain the highest attainable social, physical and emotional wellbeing. The P&P indicated a variety of activities are offered on a daily basis which includes weekends and evenings.

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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. 40913 Based on observation, interview, and record review, the facility failed to provide treatment to manage pressure ulcer (wound that occurs as a result of prolonged pressure on a specific area of the body) and promote healing for one of two sampled Residents (Resident 37) for Pressure Ulcer care area, when the facility failed to ensure the resident's low air loss (LAL, operates using a blower based pump that is designed to circulate a constant flow of air through the mattress, commonly used to heal pressure ulcers) mattress was on alternating therapy and not on static (lacking in movement) mode. This deficient practice had the potential to delay the healing of Resident 37's stage 4 pressure ulcer (full thickness skin and tissue loss with exposed or directly palpable fascia, muscle, tendon, ligament, cartilage or bone in the ulcer). Findings: A review of Resident 37's Admission Record indicated the facility initially admitted the resident on 8/20/2023 and readmitted the resident on 2/21/2024, with diagnoses that included type 2 diabetes (a disease in which the body's ability to produce or respond to the hormone insulin is impaired, resulting in elevated levels of glucose/sugar in the blood and urine) and cervical disc disorder at C5-C6 level with radiculopathy (pinched nerve that causes pain, weakness, numbness.) During a review of Resident 37's Minimum Data Set (MDS, a standardized assessment and care planning tool), dated 3/6/2024, indicated the resident was rarely able to express ideas and wants and was rarely able to understand verbal content. During an observation on 3/29/2024 at 6:51 pm with the Director of Nursing, Resident 37 was lying on a LAL mattress, which was set at static mode. During an interview on 3/31/2024 at 3:09 pm, the Assistant Director of Nursing (ADON) stated she did not know the static needed to be off. During an interview on 3/31/2024 at 5:28 pm, the Director of Nursing stated when the static setting was on that would mean the air on the mattress was steady instead of the air moving to different sections of the mattress. The DON stated the static setting on the LAL mattress would only be used for cleaning, changing positions and when turning the resident. The DON stated, We needed to ensure the static mode was off by turning off the light, if the light is on where it indicated static then the static mode is on. A review of the User Manual for the LAL mattress indicated the mattress has 20 individual air cells that provides a specialty surface that helps conform to the specific shape of the resident, minimizing soft tissue distortion, helping reduce bone penetration into muscle fascia, and helping promote improved blood flow compared to traditional surfaces. The system has a static button available to discontinue alternation therapy for patient transfers, caregiving, comfort, or preference. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055464	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/31/2024
NAME OF PROVIDER OR SUPPLIER Two Palms Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 2637 E. Washinton Blvd Pasadena, CA 91107	

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the facility's Policy and Procedure (P&P) titled, Pressure Ulcer Prevention, revised 6/1/2017, indicated licensed staff will monitor interventions for effectiveness and resident tolerance.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. 40913 Based on observation, interview, and record review, the facility failed to assess and monitor for the presence of sediments on the suprapubic catheter (a tube placed in the bladder through a cut in the lower part of the abdomen to drain and collect urine from the bladder) tubing for one of two residents (Resident 11), for Catheter care area. This deficient practice had the potential to lead to a urinary tract infection (UTI, condition in which bacteria invade and grow in any part the urinary system which includes the kidneys, bladder, ureters [tube that carries urine from the kidney to the urinary bladder], and urethra [canal from the bladder]) and delay in treatment. Findings: A review of Resident 11's Admission Record indicated the facility admitted the resident on 12/28/2023, with diagnoses that included cerebral infarction (stroke,) cystostomy (a surgical procedure that connects the bladder and the skin to drain urine through a tube. A review of Resident 11's Minimum Data Set (MDS, a standardized assessment and care planning tool), dated 3/18/2024, indicated Resident 11 sometimes able to express ideas and wants and sometimes able to understand verbal content. During an observation on 3/29/2024 at 7:50 pm, there were sediments observed on the catheter tubing. Licensed Vocational Nurse 4 (LVN 4) came to Resident 11's room but did not check the catheter. LVN 4 stated she moved the catheter to the left side so the tubing was not visible upon entering the room. During an interview on 3/30/2024 at 5:10 pm, the Assistant Director of Nursing (ADON) stated, When sediments would be observed on the urine, we could be concerned with possible infection. We need to monitor the urine for sediments. During a concurrent observation and interview on 3/30/24 at 5:13 pm with the ADON. ADON stated, there were sediments observed on the catheter tubing and there were sediment deposits at the bottom of the urine bag. The ADON stated the grain like particles at the bottom of the bag and on the catheter tubing were sediments. During an interview on 3/30/24 at 5:24 pm, the ADON stated there was no documentation that sediments were observed in Resident 11's urine and on the catheter tubing. The ADON stated, We needed to notify the physician because the presence of sediments in the urine is not normal and that could be a change in resident's condition and we are concerned with possible infection. During an interview on 3/30/2024 at 5:34 pm, LVN 4 stated monitoring the urine for color, presence of sediments were part of nursing assessment for residents with a urinary catheter. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Two Palms Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 2637 E. Washinton Blvd Pasadena, CA 91107	

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident 11's care plan for suprapubic catheter indicated to monitor for discharge, redness on site and sediments. A review of the facility's Policy and Procedure titled, Change in Condition Notification, revised 6/1/2017, indicated the licensed nurse will notify the resident's attending physician when there is a significant change in the resident's mental, physical or psychosocial status, life-threatening conditions or clinical complications. During a review of the facility's Policy and Procedure (P&P) titled, Care of Catheter-Suprapubic, revised 6/1/2017, indicated to document any unusual observations in the medical record.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40037 Based on observation, interview and record review, the facility failed to provide an appropriate food texture to fit the resident's need for one out of two sampled residents (Resident 41), for Nutrition care area. This failure had potential for Resident 41 to lose more weight and result in malnutrition (faulty nutrition due to inadequate or unbalanced intake of nutrients). Findings: A review of Resident 41's admission record indicated Resident 41 was readmitted to the facility on [DATE], with diagnoses that included dehydration (use or lose more fluid than intake, the body doesn't have enough water and other fluids to carry out tis normal functions) and type 2 diabetes mellitus (a condition that happens because of a problem in the way the body regulates and uses sugar as a fuel). A review of Resident 41's Minimum Data Set (MDS, a resident assessment and screening tool), dated 3/5/2024, indicated Resident 41 had clear speech, understood others and made self-understood. Resident 41 required partial/moderate assistance (helper does less than half the effort) for eating and substantial/maximal assistance (helper does more than half the effort) for oral hygiene, upper body dressing and personal hygiene. A review of Resident 41's Order Summary Report, dated 3/31/2024, indicated Resident 41 was on fortified (a food that has extra nutrients added to it) Consistent, controlled carbohydrate (CCHO) diet, regular, cut up meat texture. A review of Resident 41's Dietary notes (DN) for weekly weight review by Registered Dietitian and interdisciplinary team (IDT), dated 3/22/2024, indicated Resident 41 had a four pound (lb) weight loss within a week. The DN indicated Resident 41's po (by mouth) intakes continued to be poor at 30-40 percent and Resident 41 was on feeding program. The DN indicated Resident 41's weight loss was related to poor po intakes, advanced age, chewing difficulty, possible depression (a constant feeling of sadness and loss of interest, which stops person doing normal activities). During an interview on 3/29/2024 at 6:55 pm, Resident 41's Responsible Party (RP 1) stated, Resident 41 had difficulty to chew the food the facility provided. RP 1 stated Resident 41 had experienced weight loss recently. During an observation on 3/30/2024 at 5:25 pm, in Resident 41's room, Resident 41 was in bed sitting up with one staff assisting Resident 41's meal. Resident 41's dinner tray had a ham sandwich, a chopped boiled egg and a vegetable soup. Resident 41 took 100% soup, picked out small pieces of vegetable leaf out of mouth. The staff gave Resident 41 a couple pieces of chopped egg, Resident 41 tried to chew on them, and then picked them out by hand. Resident 41 was not able to chew on sandwiches that was prepared. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Two Palms Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 2637 E. Washinton Blvd Pasadena, CA 91107	

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 3/30/2024 at 5:35 pm, Certified Nursing Assistant (CNA2) stated, Resident 41 had difficulty chewing the food offered in the tray. CNA2 stated Resident 41 took all the soup and HPN (high protein nutrition) drink and had no difficulty swallowing. During an interview on 3/30/2024 at 5:46 pm, Licensed Vocational Nurse 1 (LVN 1) stated, Resident 41 had no problem with swallowing, but had difficulty chewing. LVN 1 stated the facility should provide more appropriate food texture for Resident 41 to prevent possible further weight loss and malnutrition. During a concurrent interview, the Director of Nursing (DON) stated, Resident 41' DN indicated Resident 41 had difficulty chewing, the facility should talk to Resident 41's physician and dietitian to offer Resident 41 a better food texture to fit the needs and to increase Resident 41's food intake to prevent further weight loss and malnutrition. A review of the facility's policy and procedure titled, Assessment and Management of Resident Weights, revised 6/1/2017, indicated To ensure that each resident maintains acceptable parameters of weight and nutritional status, such as body weight and protein level, unless the resident's clinical condition demonstrates that this is not possible based on the resident's comprehensive assessment. Significant weight change management: The IDT care plan will be updated to reflect individualized goals and approaches for managing the weight change.

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. 42781 Based on observation, interview, and record review, the facility failed to ensure Licensed Vocational Nurse 2 (LVN 2) flushed (cleansed) the gastrostomy tube (GT-a tube inserted into the stomach through a surgical incision use for feeding and administration of medication for a resident unable to swallow) before and after medication administration for one of 28 sampled residents (Resident 29) in accordance with the facility's policy and procedure titled Feeding Tube - Administration of Medication. This deficient practice had the potential to result in inconsistent effectiveness of medication for Residents 29. Findings: During a review of Resident 29's Admission Record, the admission record indicated the facility admitted Resident 29 on 3/26/2023 with diagnoses that included encounter for attention to gastrostomy (creation of an artificial external opening into the stomach for nutritional support) and dementia (long term and often gradual decrease in the ability to think and remember severe enough to affect a person's daily functioning). During a review of Resident 29's Order Summary Report, dated 3/27/2023, indicated, to flush GT with 20 cubic centimeters (cc, unit of measurement) of water before and after medication administration. During a review of Resident 29's History and Physical (H&P), dated 3/29/2023, the record indicated, Resident 29 did not have the capacity to understand and make decisions. During a review of Resident 29's Minimum Data Set (MDS, a standardized assessment and care planning tool), dated 1/29/2024, the MDS indicated, Resident 29 's cognition (mental action or process of acquiring knowledge and understanding) for daily decision making was severely impaired. The MDS indicated, Resident 29 was dependent to staff with oral hygiene, toileting, shower, and personal hygiene. During a review of Resident 29's Order Summary Report, dated 2/16/2024, indicated, Isosource (milk supplement) 1.5 at 60 millimeter (ml, unit of measurement) per hour (hr) for 20 hours to provide 1,800 kilocalories (kcal) for dysphagia (difficulty in swallowing). During a medication pass observation on 3/30/2024 at 9:04 am, the Licensed Vocational Nurse (LVN) 2 flushed Resident 29's GT with 10 centimeters (cc, unit of measurement) of water before administering medications. During an observation on 3/30/2024 at 9:31 am, the LVN 2 flushed Resident 29's GT with 30 cc of water after administering medications. Observed 30cc of water was spilled on Resident 29's clothing. During an interview on 3/30/2024 at 9:35 am, LVN 2 stated, the 30 cc of water used to flush Resident 29's GT was spilled in Resident 29's clothing. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Two Palms Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 2637 E. Washinton Blvd Pasadena, CA 91107	

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 3/30/2024 at 9:38 am, with the facility's Director of Nursing (DON), the DON stated, GT should be flushed with 20cc to 30cc of water before and after administering medication to prevent the GT from clogging. During a review of the facility's Policy and Procedure titled, Feeding Tube - Administration of Medication, revised 6/1/2017, the P&P indicated, after establishing that the tube was patent and in correct position, .etc, flush tube with approximately 30 cc's of water. The P&P indicated, flush with 30 cc's of water after the final medication is administered.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40037 Based on observation, interview, and record review, the facility failed to ensure two of two sampled residents (Resident 17 and 15), for Respiratory care area, receiving oxygen therapy were provided respiratory care and services in accordance with the facility's Oxygen Administration policy and procedure and professional standard of practice by failing to ensure: a. Resident 17's nasal cannula tubing (flexible plastic tubing used to deliver oxygen through nostrils and the tubing is fitted over the patient's ears) was labeled, rolled and inserted to the handle of oxygen concentrator (a medical device that concentrates oxygen from environmental air and delivers it to the resident in need of supplemental oxygen) and cautionary sign posted on the resident's door indicating oxygen in use. b. Resident 15's nebulizer (a device that turns the liquid medicine into a mist which is then inhaled through a mouthpiece or a mask) bag and its connecting tubing off the floor. These failures have the potential for Resident 17 and 15 get infection. Findings: a. A review of Resident 17's Admission Record indicated the facility admitted Resident 17 on 12/20/2023 with diagnoses that included history of falling and Chronic Obstructive Pulmonary Disease (COPD, type of obstructive lung disease characterized by long-term poor airflow). A review of Resident 17's Minimum Data Set (MDS, a standardized assessment and care planning tool), dated 3/15/2024, the MDS indicated, Resident 17 's cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decision making was severely impaired. The MDS indicated, Resident 17 required moderate assistance with shower and lower body dressing. The MDS indicated, Resident 17 was dependent to staff during toileting hygiene. A review of Resident 17's Physician Order's, dated 11/29/2023, indicated to administer oxygen at three (3) liters per minute (L/min) via nasal cannula as needed to keep oxygen saturation (amount of oxygen carried in blood) above 92% for shortness of breath related to COPD. During an observation on 3/29/2024 at 6:32 pm, Resident 17 was asleep lying in bed with nasal cannula tubing rolled and inserted in the handle of the oxygen concentrator. During a concurrent observation and interview on 3/29/2024 at 6:33 pm, with Licensed Vocational 1 (LVN 1), Resident 17 was asleep lying in bed. Observed Resident 17's unlabeled nasal cannula tubing was rolled and inserted in the handle of the oxygen concentrator. LVN 1 stated, nasal cannula tubing should be placed inside the storage bag with residents name and date when was it changed. LVN 1 stated, nasal cannula should be labeled with residents name and date when was it changed and needed to be placed inside the storage bag for infection control. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Two Palms Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 2637 E. Washinton Blvd Pasadena, CA 91107	

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent observation and interview on 3/29/2024 at 7:01 pm, LVN 1 stated there was no sign posted on Resident 17's door indicating oxygen was in use in the room or smoking was prohibited. LVN 1 stated there should be a smoking sign to remind everyone not to smoke inside the room because oxygen was flammable. During an interview on 3/30/2024 at 4:20 pm, with the facility's Director of Nurses (DON), the DON stated nasal cannula should be labeled with residents name and needed to be dated and if not in use, it should be stored in the storage bag for infection control. The DON stated, smoking sign should be posted at the entrance door of residents receiving oxygen therapy to let the visitor know not to smoke to avoid fire and for residents safety. b. A review of Resident 15's Admission Record indicated Resident 15 was admitted on [DATE], with diagnoses that included difficulty walking, dysphagia (difficult swallowing) and depression (a constant feeling of sadness and loss of interest, which stops you doing your normal activities). A review of Resident 15's Minimum Data Set (MDS, a resident assessment and care screening tool) dated 3/1/2024, indicated, Resident 15 had clear speech, had ability to express ideas and wants and had ability to understand others. Resident 15 was cognitively intact (able to think, reasoning and organize). Resident 15 required substantial/maximal assistance (helper does more than half the effort, helper lifts or holds trunk or limbs and provides more than half the effort) for chair/bed-to-chair transfer, toilet hygiene, and was partial/moderate assistance (helper does less than half the effort) for upper body dressing and personal hygiene). During a concurrent observation and interview with Infection Preventionist Nurse (IPN) on 3/29/2024 at 6:40 pm, in Resident 15's room, IPN stated Resident 15's nebulizer bag was hanging on Resident 15's night stand draw knob with lower part of the bag and the connecting tubing touching the floor. IPN stated Resident 15's nebulizer bag and the tubing should be kept off the floor for infection control purposes. A review of the facility's policy and procedure (P&P) titled, Oxygen Administration, revised 6/1/2017, indicated, oxygen items will be stored in a plastic bag at the resident's bedside to protect equipment from dust and dirt when not in use. The P&P indicated, residents using oxygen will have an Oxygen in Use sign placed on the door frame of their room. P&P indicated, no smoking is allowed around oxygen therapy equipment. 42781

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40913 . Based on observation, interview, and record review, the facility failed to attempt appropriate alternatives prior to installing a side or bed rail for one of 17 sampled residents (Resident 40). This deficient practice had the potential for the side or bed rail to present as a safety hazard to Resident 17. Findings: A review of Resident 40's Admission Record indicated the facility admitted the resident on 9/20/2023, with diagnoses that included Alzheimer's disease (irreversible, progressive brain disorder that slowly destroys memory and thinking skills, and eventually the ability to carry out the simplest tasks) and anxiety disorder (group of mental disorders characterized by feelings of anxiety [an unpleasant state of inner turmoil] and fear.) A review of Resident 40's MDS dated [DATE], indicated Resident 40 sometimes was able to express ideas and wants and sometimes was able to understand verbal content. The MDS indicated Resident 40 required maximal assistance (helper does more than half the effort) with rolling left to right and dependent with lying to sitting mobility. During an observation on 3/30/24 at 4:10 pm with the Assistant Director of Nursing (ADON), Resident 40 had removed the padding that was placed on the siderails and had inserted her legs in between the siderails. During a concurrent record review and interview with the ADON on 3/30/24 at 6:10 pm, the ADON stated the Side Rail/Restraint/Device Assessment, dated 12/6/2023, indicated the alternative attempted prior to the use of siderails was frequent monitoring, no other appropriate alternatives was attempted. The ADON stated the use of siderails is an accident hazard because it could put the residents at risk for entrapment. The ADON stated appropriate alternatives would be the use of low bed, fall mats, and bolsters. A review of the facility's Policy and Procedure titled, Bedrails revised 10/24/2022, indicated the assessment of whether to use bed rails should include an evaluation of the alternatives to the use of bed rail that were attempted and how these alternatives failed to meet the resident's assessed needs. Alternatives attempted should be appropriate for the resident, safe and address the medical conditions, symptoms or behavioral patterns for which a bed rail was considered.

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NAME OF PROVIDER OR SUPPLIER: Two Palms Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE: 2637 E. Washinton Blvd Pasadena, CA 91107	

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. 42781 Based on interview, and record review, the facility failed to ensure competent nursing staff by failing to conduct and complete the performance evaluation for one of five staff (Licensed Vocational Nurse 4 [LVN 4]) as indicated in the facility's policy and procedure titled, Performance Evaluations This deficient practice had the potential for residents not receive appropriate nursing care and services. Findings: During a concurrent record review of LVN 4's employee file and interview on 3/31/2023 at 12:20 pm with the Director of Staff and Development (DSD), the DSD stated LVN 4 worked full time in the facility since 1/27/2022. The DSD stated there was no documentation that LVN 4's performance evaluation was done by the Director of Nursing (DON). The DSD stated performance evaluation should be conducted annually by the DON. During an interview on 3/31/2024 at 4:10 pm with the facility's DON, the DON stated she was responsible to conduct the performance evaluation of Licensed staff. The DON stated the Performance evaluation should be done annually to evaluate the staff performance if able to provide competent care to residents. During a review of the facility's policy and procedure titled, Performance Evaluation, reviewed 5/2022, indicated performance evaluation may be conducted annually on or around their anniversary date.

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Some	Post nurse staffing information every day. 42781 Based on observation, interview and record review, the facility failed to post accurate nurse staffing information of actual hours worked by the licensed and unlicensed nursing staff directly responsible for resident care per shift daily and was not posted in a prominent location readily accessible to residents and visitors for viewing in accordance with the facility's policy and procedure titled Nursing Department - Staffing, Scheduling and Posting. This deficient practice of posting inaccurate nurse staffing information could mislead the residents and visitors that may affect the quality of nursing care provided to the residents. Findings: During an observation on 3/29/23 at 8:24 pm, the facility's staffing information was not posted in the nurses' station and/or visible areas. During a concurrent interview and record review on 3/29/24 at 8:29 pm, the Regional Director of Staff Development (RDSD) stated she could not find the staffing information posting. The RDSD stated, staffing information posting should be posted in visible areas so staff, visitors and residents could access easily. The RDSD stated, staffing posting should be posted in visible areas for the visitors and residents to know how many nurses were taking care of the residents. During a concurrent interview and record review on 3/31/2024 at 10:40 am with DSD, the nurse staffing information and the actual staffing sign in sheet for the staff who worked in the facility reflected the following: 1. On 3/29/2024 for the 11 pm to 7 am shift, there was 1 Registered Nurse (RN) on the nursing staffing posting while the sign in sheet reflected no RN worked for the night 11 pm to 7 am shift on 3/29/2024. 2. On 3/29/2024 for the 11 pm to 7 am shift, there were 5 Certified Nurse Assistant (CNA) on the nursing staffing posting while the sign in sheet reflected 4 CNAs worked for the night 11 pm to 7 am shift on 3/29/2024. During an interview on 3/31/2024 at 10:20 am, the DSD, the DSD stated, that it was important that the nursing staffing information posted was correct to ensure the facility met the staffing requirement to provide patient care and not to create inaccuracy to the staff and visitors. The DSD stated, During a review of facility's policy and procedure titled, Nursing Department - Staffing, Scheduling and Posting, revised 10/24/2022, the P&P indicated, the facility will post the total number and actual hours worked by the licensed and unlicensed nursing staff directly responsible for resident care per shift. The P&P indicated, the facility will post the nurse staffing data on a daily basis at the beginning of each shift and data must be posted in a prominent place readily accessible to residents and visitors.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055464	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Two Palms Care Center	2637 E. Washinton Blvd Pasadena, CA 91107

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40037 Based on observation, interview, and record review, the facility failed to administer Cyanocobalamin (a synthetic compound of vitamin B12 used to treat vitamin deficiencies) to one of six sampled Residents (Resident 5) as ordered. This failure had the potential to result in Resident 5's developing vitamin B12 deficiencies causing anemia (a problem of not having enough healthy red blood cells or hemoglobin to carry oxygen to the body's tissues), fatigue and decline in health conditions. Findings: A a review of Resident 5's admission record indicated Resident 5 was readmitted to the facility on [DATE], with diagnoses that included anemia and vitamin D deficiency. A review of Resident 5's Minimum Data Set (MDS, a resident assessment and care screening tool), dated 12/28/23, indicated Resident 5 had clear speech, sometimes understood others, and sometimes made self-understood. A review of Resident 5's Order Summary Report, dated 3/30/2024, indicated Resident 5 was prescribed Cyanocobalamin oral tablet 100 mcg (microgram) one tablet by mouth one time a day for supplement. During a medication administration observation on 3/20/2024 at 8:53 am, Licensed Vocational Nurse 3 (LVN 3) administered vitamin B1 100mg (milligram) one tablet to Resident 5. During an interview on 3/20/2024 at 9:14 am, LVN 3 stated, LVN 3 gave the wrong medication and wrong dose to Resident 5. LVN 3 stated, the physician order was for Resident 5 to be given Cyanocobalamin 100 mcg which was vitamin B12, and LVN 3 administered vitamin B1 100 milligrams (mg). LVN 3 stated, it was important to ensure the right resident, right drug, right dose, right route and right time when doing medication administration to avoid medication errors for resident's health and safety. During an interview with the Director of Nursing (DON), the DON stated, The facility licensed staff should check for right name, right medication, right dose, right route, and right time during medication administration. The DON stated it was for resident's right, safety, and health. The DON stated, Giving the wrong medication could cause harm to residents and delay their healing process. A review of the facility's policy and procedure titled, Medication-Administration, revised 6/1/2017, indicated Medication will be administered by a licensed nurse per the order of an attending physician or licensed independent practitioner. No medication will be used for any resident other than the resident for whom it was prescribed. The licensed nurse must know the following information about any medication they are administering: the drug's name (generic and trade) and the drug's usual dosage. Nursing staff will keep in mind the seven rights of medication when administering medication: the right medication, the right amount, the right resident, the right time .

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. 40913 Based on observation, interview and record review, the facility failed to ensure one of 5 sampled residents (Resident 23), for unnecessary medication care area, was free from the use of unnecessary psychotropic drug (any medication capable of affecting the mind, emotions, and behavior) by failing to monitor the target behavior for the use of Seroquel (antipsychotic medication). This deficient practice had the potential to place Resident 23 at risk for significant adverse consequence (unwanted, uncomfortable, or dangerous effects that a drug may have) from the use of unnecessary psychotropic drug, which could result to impairment or decline in the residents' mental, physical condition, functional, and psychosocial status. Findings: A review of Resident 23's Admission Record indicated the facility readmitted the resident on 2/22/2024, with diagnoses that included paraplegia (impairment in motor or sensory function of the lower extremities) and contracture (shortening and hardening of muscles, tendons, or other tissue, often leading to deformity and rigidity of joints) of bilateral elbows and knees. A review of Resident 23's Minimum Data Set (MDS, a standardized assessment and care planning tool), dated 5/7/2024, indicated the resident was rarely able to express ideas and wants and was rarely able to understand verbal content. The MDS indicated Resident 23 was dependent with all activities of daily living. During a concurrent record review and interview on 3/31/24 3:36 pm with the Assistant Director of Nursing (ADON,) ADON stated Resident 23 had an order for Seroquel 25 milligrams (mg) at bedtime for psychosis manifested by episodes of yelling/screaming, delusions (an unshakable belief in something untrue), hallucinations (an experience in which you see, hear, feel, or smell something that does not exist). ADON stated the medication was started on 2/22/2024. The ADON stated Resident 23's monitoring for yelling, screaming, delusions, hallucinations on the MAR did not allow staff to write the number of times, instead the MAR only allowed initials of the nurse. The ADON stated she is fixing it now to allow licensed nurse to put in the tally number for their shift. During an interview on 3/31/2023 at 3:44 PM, the ADON stated the facility need to monitor how many times the behavior occurred per shift and tally at the end of the month to be able to determine if the use of Seroquel was effective or if there was an opportunity to do a gradual dose reduction.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40037 Based on observation, interview and record review, the facility failed to ensure medication room free from expired medication for one out of one medication storage room. This failure had the potential to result in the residents using ineffective medications which could cause a decline in the Residents' health conditions. Findings: A review of Resident 40's Admission Record indicated Resident 40 was admitted to the facility on [DATE], with diagnoses that included depression (a constant feeling a sadness and loss of interest, which stops person from doing normal activities) and hypertension (increased blood pressure). A review of Resident 40's Physician Order Summary report, dated 3/30/2024, indicated, Lorazepam Intensol Oral Concentrated was not on Resident 40's current medication list. A review of Resident 40's Physician Order, dated 11/7/2023, indicated Lorazepam Oral Concentrate 2mg/ml (milligram per milliliter), give 0.5ml by mouth every 4 hours as needed for seizures (sudden, uncontrolled body movement and changes in behavior that occur because of abnormal electrical activity in the brain. Symptoms include loss of awareness, changes in emotion, loss of muscle control and shaking) for 30 days and give 0.5 ml by mouth every 4 hours as needed for anxiety/restlessness for 30 days. During a concurrent inspection of the facility's medication storage room and interview with the Director of Nursing (DON) on 3/30/2024 at 11:26 am, the DON stated, there was a bottle of Lorazepam Intensol Oral Concentrated (a medication used to treat anxiety {act on the brain and nerves to produce a calming effect and works by enhancing the effects of a certain natural chemical in the body}), dated 10/23/2023, in the medication refrigerator. The DON stated the bottle was labeled with Resident 40's name and dated 10/23/2023, which was the date the bottle was opened. The DON stated, the facility should not keep this medication in the medication refrigerator because it was already expired. The DON stated, This medication expired 30 days after opening per the facility's policy. The DON stated, This medication was used to treat anxiety, and if the medication expired, it might lose its effectiveness and if given expired medication to the resident, it might cause harm and decline to resident's health condition. The DON added Resident 40 was not currently taking Lorazepam since the prescription was expired on 12/6/2023. The DON stated the facility staff forgot to discard the medication. During an review of the facility's Policy and Procedure titled, Medication Storage in the Facility, dated 1/2022, indicated, When the original seal of a manufacturer's container or vial is initially broken, the container or vial will be dated. The nurse shall place a date opened sticker on the medication and enter the date opened and the new date of expiration. The expiration date of the vial or container will be 30 days unless the manufacturer recommends another date or regulations/guidelines require different dating. All expired medications will be removed from the active supply and destroyed in the facility, regardless of amount remaining.

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. 42781 Based on observation, interview, and record review, the facility failed to ensure Cook 1 followed the menu for 16 of 16 residents on mechanical soft diet. This deficient practice had the potential for Residents to have a weight loss, which could affect residents' over all well being. Findings: During a kitchen observation on 3/31/2024 from 11:40 am to 12:37 pm, the trayline included the following food: ham, broccoli, sweet potatoes, mechanical soft ham, pureed ham, pureed sweet potato, pureed broccoli, ground broccoli, ground bread, and pureed sweet potato. During this same observation, Cook 1 used a green scoop for ham when portioning for the mechanical soft diet. During an interview on 3/31/2024 at 12:38 pm, Cook 1 stated he used the #12 scoop for mechanical soft ham, Cook 1 stated #12 scoop is the green colored scoop. During a concurrent review of the Spring Cycle Menu for Week 1 Sunday Menu, the Menu indicated to use #10 scoop. The Cook stated they did not have the #10 scoop and he had asked the Dietary Services Supervisor (DSS) to order the #10 scoop. The Cook stated #12 scoop is smaller than the #10 scoop. During a review of the kitchen's posted scoop size diagram, the posting indicated green scoop (#12 scoop) had a capacity of 2 2/3ounce (oz). The posting indicated #10 scoop had a capacity of 3 1/4 oz. The difference of 0.58 oz. During a review of the facility's Diet Type Report with printed on 3/31/2024, the report indicated there were 16 residents on mechanical soft diet. During an interview on 3/31/24 at 5:37 pm, the DSS stated the kitchen had not needed the #10 scoop for a long time until this new menu, the DSS stated the new menu started approximately two weeks ago. During a review of the Spring Menu from 3/4/2024 to 3/23/2024, indicated the #10 scoop was indicated to be used on the menu for 14 out of 21 days. During a review of the facility's Policy and Procedure (P&P) titled, Dietary Department, dated 10/24/2022, indicated that the dietary department has the requisite organization to meet the nutritional needs of the residents. The P&P indicated the primary objectives of the dietary department include maintenance of accurate records for planning and control of the dietary department's food and non-food supply .provision of effective supervision and training of food service personnel.

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F 0814 Level of Harm - Potential for minimal harm Residents Affected - Many	Dispose of garbage and refuse properly. 40913 Based on observation, interview, and record review, the facility failed to ensure trash was disposed properly for one of two dumpsters. This deficient practice had the potential for harboring of pest. Findings: During an observation on 3/29/2024 at 6:32 pm with Cook 1, there were two dumpsters outside the facility. One dumpster was full of trash and the lid could not be closed all the way. During a concurrent interview, Cook 1 stated both kitchen trash and resident trash would be thrown at both dumpsters. Cook 1 stated, the garbage collection comes twice a week. Cook 1 stated both dumpsters needed to be covered because the kitchen waste could attract rats, flies and other pests. During an interview on 3/30/2024 at 11:30 am, the Administrator provided a policy on Medical and Pharmaceutical Waste Management Program and was not able to provide a policy on Waste management for both Resident and kitchen trash.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40037 Based on interview and record review, the facility failed to offer pneumococcal vaccine (protects against serious and potentially fatal pneumococcal disease that caused by bacteria called Streptococcus pneumoniae [pneumococcus] based on Centers of Disease Control and Prevention [CDC] recommended schedule guidelines for one out of five sampled residents (Resident 8). This failure had the potential to result in leaving residents at risk of acquiring, transmitting, or experiencing complications from pneumococcal disease. Findings: A review of Resident 8's Admission Record indicated Resident 8 was readmitted to the facility on [DATE] with diagnoses included hypertension (increased blood pressure) and dementia (loss of memory, language, problem-solving and other thinking abilities). Resident 8's AR indicated Resident was [AGE] years old. A review of Minimum Data Set (MDS, a resident assessment and care screening tool), dated 3/16/23, indicated Resident 8 rarely/never understood others and rarely/never made self-understood. A review of Resident 8' Immunization Audit Report (IAR), indicated, Resident 8 received one dose of Pneumovax (a vaccine indicated for active immunization for the prevention of pneumococcal disease) on 1/4/2016. The report indicated there was no other pneumococcal vaccine provided to Resident 8 from 1/5/2016 to 3/31/2024. During an interview on 3/31/2024 at 9:46 am, Infection Preventionist Nurse (IPN) stated, Resident 8 received one dose of pneumococcal vaccine on 1/4/2016. IPN stated Resident 8 received that dose before being admitted to the facility and was the last time Resident 8 received a pneumococcal vaccine. IPN stated, based on Resident 8's IAR, Resident 8's last dose of pneumococcal vaccine was more than 5 years ago and according to CDC's guideline, Resident 8 should have received another dose of pneumococcal vaccine, especially since the resident is more than [AGE] years old. IPN stated Resident 8 should have been given the opportunity to receive pneumococcal vaccine and be informed alongside resident's Responsible Party (RP) about the benefits and risks of the immunization. IPN stated according to CDC guidelines, another dose of pneumococcal vaccine should be provided around early 2021. IPN stated, Resident 8 or RP was not not given education on the pneumococcal vaccine. IPN stated Resident 8 was not offered pneumococcal vaccine. IPN stated, it was important to keep residents up to date with immunizations to prevent residents from acquiring pneumococcal disease and experiencing possible respiratory distress and hospitalization . A review of the facility's policy and procedure titled, Pneumococcal Disease Prevention, revised 8/28/2024, indicated, The facility will provide education and offer the pneumococcal vaccine to residents tot prevent and control the spread of pneumococcal disease in the facility. Pneumococcal vaccine are recommended for the following classifications of residents: all adults 65 yes of age and older. If the resident has already received the pneumococcal vaccine, a second vaccination may be given in accordance with CDC recommendations.

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F 0912 Level of Harm - Potential for minimal harm Residents Affected - Some	Provide rooms that are at least 80 square feet per resident in multiple rooms and 100 square feet for single resident rooms. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42781 Based on observation, interview and record review, the facility failed to provide a minimum of 80 square feet (sq. ft., unit of measurement) per resident area for fourteen (14) out of eighteen (18) resident rooms (Rooms 1, 2, 3, 4, 5, 10, 11, 12, 13, 14, 15, 16 17 and 18). This deficient practice had the potential to impact the ability to provide safe nursing care and privacy to the residents. Findings: During an interview with the facility Administrator (ADM) on 3/31/2023 at 8:38 am, the ADM stated the facility would like to request a room waiver (a document recording the waiving of a right or claim) this year for Rooms 1, 2, 3, 4, 5, 10, 11, 12, 13, 14, 15, 16, 17 and 18. The ADM stated nothing was changed and the number of bed occupancy in the 14 rooms. During review of the facility's letter to request for room waiver dated 3/31/2024 indicated each resident had personal space provided with sufficient space including a privacy curtain, closet, and nightstand. The room waiver indicated, there was a sufficient space for the provision of routine and emergency nursing care and sufficient space for maneuvering wheelchairs to allow accessibility and freedom of movement. The room waiver indicated there was no adverse effect to the health, safety, and welfare of each resident. The waiver indicated the rooms were in accordance with special needs of residents. During a review of the Client Accommodations Analysis dated 3/31/2024 indicated the following: room [ROOM NUMBER] (0 bed) no resident occupying the room with 133.2 sq. ft. by 66.6 sq. ft. room [ROOM NUMBER] (2 beds) with 2 residents occupying the room with measurement of 144 sq. ft. by 72 sq. ft. room [ROOM NUMBER] (2 beds) with 2 residents occupying the room with measurement of 144 sq. ft. 72 sq. ft. room [ROOM NUMBER] (2 beds) with 2 residents occupying the room with measurement of 144 sq. ft. 72 sq. ft. room [ROOM NUMBER] (2 beds) with 2 residents occupying the room with measurement of 144 sq. ft. 72 sq. ft. room [ROOM NUMBER] (4 beds) with 4 residents occupying the room with measurement of 280 sq. ft. 70 sq. ft. room [ROOM NUMBER] (4 beds) with 4 residents occupying the room with measurement of 280 sq. ft. 70 sq. ft. (continued on next page)

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F 0912 Level of Harm - Potential for minimal harm Residents Affected - Some	room [ROOM NUMBER] (4 beds) with 4 residents occupying the room with measurement of 280 sq. ft. 70 sq. ft room [ROOM NUMBER] (4 beds) with 4 residents occupying the room with measurement of 280 sq. ft. 70 sq. ft. room [ROOM NUMBER] (4 beds) with 4 residents occupying the room with measurement of 280 sq. ft. 70 sq. ft. room [ROOM NUMBER] (4 beds) with 3 residents occupying the room with measurement of 280 sq. ft. 70 sq. ft. room [ROOM NUMBER] (4 beds) with 4 residents occupying the room with measurement of 280 sq. ft. 70 sq. ft. room [ROOM NUMBER] (4 beds) with 3 residents occupying the room with measurement of 280 sq. ft. 70 sq. ft. room [ROOM NUMBER] (4 beds) with 4 residents occupying the room with measurement of 280 sq. ft. 70 sq. ft. During the Health Recertification Survey, from 3/29/2024 to 3/31/2024, Rooms 1, 2, 3, 4, 5, 10, 11, 12, 13, 14, 15, 16 17 and 18 had adequate space, nursing care, comfort, and privacy to the residents. The residents were observed to have enough space to move freely inside the rooms. Each resident inside the affected rooms had beds and bedside tables with drawers. There was an adequate room for the operation and use of the wheelchairs (a chair fitted with wheels for use as a means of transport by a person who is unable to walk as a result of illness, injury, or disability) and walkers (is a device that gives additional support to maintain balance or stability while walking). The room size did not affect the care and services provided to the residents when nursing staff were observed providing care to the residents. During an interview on 3/31/2024 at 9:21 am with Certified Nurse Assistant 1 (CNA 1), the CNA 1 stated, there were enough space in the rooms and able to provide care to the residents. CNA 1 stated, she was able to move the resident's wheelchairs and walkers inside the rooms with no issues. During an interview on 3/31/2024 at 9:23 am with Licensed Vocational Nurse 2 (LVN 2), the LVN 2 stated the rooms were enough to provide care and treatment to the residents. LVN 2 stated, able to move wheelchairs and walkers inside the room with no issues. During a concurrent observation and interview on 3/31/2024 at 3:11 pm with Resident 43, Resident 43 was inside room [ROOM NUMBER], lying in bed, with wheelchair on the right side of the bed. Resident 43 stated, he was able to move his wheelchair and wheel himself in and out of the room. Resident 43 stated, the room space was ok with him.