

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055480	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/08/2024
NAME OF PROVIDER OR SUPPLIER The Californian Pasadena Healthcare		STREET ADDRESS, CITY, STATE, ZIP CODE 120 Bellefontaine Street 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)
<p>F 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Reasonably accommodate the needs and preferences of each resident.</p> <p>47362</p> <p>Based on observation, interview, and record review, the facility failed to ensure the call light device (one of the major communication technologies that link nursing home staff to the needs of residents) was answered for one (1) of four 4 sampled residents (Resident 1). On 5/7/24, Resident 1's call light was on, and it was not answered by Licensed Vocational Nurse (LVN) 1 who was standing across the resident's room, Certified Nurse Assistant (CNA) 2 and Registered Nurse (RN) 1 who passed by the room.</p> <p>This had the potential to result in a delay in care for Resident 1 not to receive the necessary care and services which can lead to illness or serious injury.</p> <p>Findings:</p> <p>A review of Resident 1's admission record indicated the facility admitted Resident 1 on 4/29/24 with diagnosis which include difficulty in walking, muscle weakness, hypertension (when the pressure in your blood vessels is too high).</p> <p>During a review of Resident 1's care plan date initiated 4/29/24 indicated Resident 1's at risk for fall. Care plan goal indicated Resident 1 will consistently use call light for assistance. The care plan intervention indicated answer call light in timely manner, encourage to call for assistance and keep call light within easy reach.</p> <p>A review of Resident 1's Minimum Data Set (MDS, standardized care and screening tool), dated 05/3/24, indicated Resident 1's cognition was intact (processes of thinking and reasoning) skills for daily decision making. The MDS indicated Resident 1 was assessed to need set up or clean up assistance (helper set up or clean up) on eating and supervision or touching assistance (helper does verbal cues) on oral hygiene, toileting hygiene, shower bathe self and personal hygiene.</p> <p>During an observation on 5/7/24 at 5:57 AM, observed the call light at Room A (Resident 1's room) was on, the Certified Nursing Assistant (CNA 2) passed by Room A and did not answer the call light. Licensed Vocational Nurse (LVN) 1 was standing across Room A at the hallway and did not answer the call light.</p> <p>(continued on next page)</p>

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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<p>F 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During concurrent observation and interview on 5/7/2024 at 6:03 AM with the CNA 1, CNA 1 saw surveyors standing outside Resident 1's room and saw the call light was on. CNA 1 went inside Room A. CNA 1 stated Resident 1 was asking for the urinal (portable receptacle into which one urinates) and blanket.</p> <p>During observation on 5/7/24 at 6:12 AM the call light at Room A was on. LVN 1 was at the hallway and did not answer the call light. Registered Nurse (RN1) passed by Room A and did not answer the call light.</p> <p>During interview on 5/7/24 at 6:17 AM with CNA 2, CNA 2 stated the call lights were connected to the nursing station and can be heard at the hallways, whoever sees it should have answered it as soon as possible for safety to prevent fall and to ensure we provide what the resident need. CNA 2 also stated everybody needs to answer the call light all the time.</p> <p>During an interview on 5/7/24 at 7:41 AM with RN 1, RN 1 stated who ever seen or heard the call light was on, the staff should answer it as soon as possible. RN 1 stated the call light of Resident 1 was not answered right away on 5/7/24 at 5:57 AM and 6:12 AM, it was possible for Resident 1 to have accident of fall. Resident 1 might not wait and will stand up to urinate. The RN 1 also stated it would affect the dignity of Resident 1 and Resident 1 will not feel comfortable and safe.</p> <p>During an interview on 5/7/2024 at 1:46 PM with Resident 1, Resident 1 stated he calls when needs his urinal and usually he waits 30 minutes to one hour before facility staff answers the resident's call light Resident 1 also stated, the day shift and evening shift is the worst and the resident have to wait long before staff answer's the resident's call light because they were busier. Resident 1 also stated he feels discouraged when the needs to wait for a long time for the facility staff to answer his call light.</p> <p>A review of the facility's policy and procedure (P&P) titled, Answering the Call Light revised date 10/2010 indicated the purpose of this procedure it's to respond to the resident's requests and needs. General guidelines indicated answer the call like as soon as possible.</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47362</p> <p>Based on observation, interview, and record review, facility failed to ensure the safety and prevent fall (unintentionally coming to rest on the ground, floor, or other lower level, but not as a result of an overwhelming external force) of two (2) of three (3) high fall risk sampled residents (Resident 2 and 3) by:</p> <ol style="list-style-type: none"> 1. The facility failed to update care plan interventions and to reassess Resident 2's fall risk assessment after the resident's fall on 4/25/2024. 2. The facility failed to update Resident 3's care plan after resident had a fall on 4/9/2024. <p>This deficient practice resulted to Resident 2 had another fall on 5/4/2024 and was sent to General Acute Care Hospital (GACH 1) and placed Resident 3 at risk for another fall incident.</p> <p>Findings:</p> <ol style="list-style-type: none"> 1. A review of Resident 2's admission record indicated the facility admitted Resident 2 on 4/22/24 with diagnosis which include muscle weakness, difficulty in walking, traumatic subarachnoid hemorrhage (traumatic head injury, resulting in bleeding) <p>A review of Resident 2's H&P dated 4/30 /24 indicated Resident 2 does not have the capacity to make decisions.</p> <p>A review of Resident 2's Minimum Data Set (MDS, standardized care and screening tool), dated 4/26/24, indicated Resident 2 was moderate impaired with cognitive (processes of thinking and reasoning) skills for daily decision making. The MDS also indicated Resident 2 needs supervision or touching assistance (helper provides verbal cue and or touching steadily and or contact guard assistance as resident completes activity) on eating, oral hygiene, upper body dressing, personal hygiene, partial moderate assist (helper does less than half the effort) on toileting hygiene and personal hygiene. The MDS also indicated, the following activities was not attempted due to medical condition or safety concerns, walking 10 feet on uneven surfaces (ability to walk 10 feet) and picking up object.</p> <p>During concurrent interview 5/8/2024 at 5:47 PM and record review of Resident 2's fall risk assessment dated [DATE] indicated Resident 2 was high risk for fall. The Minimum Data Set Coordinator nurse (MDSC) stated there was no documented evidence of fall risk assessment was done after Resident 2's incident of fall on 4/25/2024.</p> <p>During a review of Resident 2's Progress Notes dated 4/25/24 at 9:46 AM indicated the charge nurse was alerted by the house keeping that Resident 2 was on the floor. The progress notes also indicated, the charge nurse rushed to Resident 2's bedside and Resident 2 was noted to have blood running down his face. Resident 2 was transferred to GACH 1 via ambulance at 12PM.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a review of Resident 2's Progress Notes dated 4/25/24 at 10:19 PM, indicated Resident 2 returned from GACH 1 at 8:30 PM with laceration on the scalp with stitches (also called sutures, are special types of thread that hold the edges of a wound together while it heals in place).</p> <p>During a review of Resident 2's Progress Notes dated 5/4/24 at 11:47 PM (late entry) indicated around 11:05 PM Resident 2 was found on the floor in right lateral recumbent position (lying on the right side) and making snoring sound. Resident 2 was unresponsive. The progress notes also indicated that the Resident 2 was transferred to GACH 1 via 911 (three-digit number anyone can dial on the telephone to get help when there is a life-threatening or in-progress emergency).</p> <p>During a review of Resident 2's GACH 1 ED notes dated 5/4/24 at 11:44 PM indicated Resident 2 was brought in by ambulance (BIBA) from the facility for unwitnessed fall. The GACH 1 ED notes also indicated Resident 2 was noted to have a gold- sized hematoma on right forehead.</p> <p>During concurrent interview and record review on 5/8/24 at 5:47 PM with the MDSC of Resident 2's Care Plan dated initiated 4/22/24, revised date 5/3/2024 indicated Resident 2 is at risk for fall related to gait balance problem, psychoactive drugs (drug or other substance that affects how the brain works and causes changes in mood, awareness, thoughts, feelings, or behavior) use, unaware of safety needs, and wandering(a patient who goes beyond the view or control of staff without the intention of leaving the health care facility). The care plan goal indicated Resident 2 will be free of fall and will not sustain serious injury. The MDSC stated after Resident 2's fall on 4/25/24, the resident's care plan was not reviewed and updated to ensure interventions are in place to prevent another fall. The MDSC stated the licensed nurses should have updated the care plan as soon as there's a change of condition or fall and the licensed nurses should have been looking for new interventions to try to keep resident safe and prevent another fall.</p> <p>During the same interview on 5/8/24 at 5:47 PM with MDSC, MDSC stated on 4/26/24 Resident 2 was originally in Room A near the nursing station, then on 4/26/24 the resident was transferred to r Room B and Room B is far from the nursing station. MDSC also stated, based on the Resident 2's MDS dated [DATE], Resident 2 needs supervision with assistance on toileting and the resident should have a facility staff to assist the resident to the bathroom, from bed to standing up should have somebody assisting the resident. MDSC also stated, if the resident was provided with assistance on 4/25/24 and 5/4/24 the fall could have been prevented.</p> <p>2. A review of Resident 3's admission record indicated the facility initially admitted Resident 3 on 2/6/24 and readmitted on [DATE] with the following diagnosis difficulty walking, muscle weakness, thrombocytopenia (a condition in which there is a lower-than-normal number of platelets in the blood. It may result in easy bruising and excessive bleeding from wounds or bleeding in mucous membranes and other tissues).</p> <p>A review of Resident 3's MDS, dated [DATE], indicated Resident 3 's cognition was intact skills for daily decision making. The MDS also indicated Resident 3 needs supervision or touching assistance (helper provides verbal cue and or touching steadily and or contact guard assistance as resident completes activity) on eating oral hygiene, substantial maximal assistance (helper does more than half of the effort) on toileting hygiene, shower bathe self-upper and lower body dressing. The MDS indicated toilet transfer chair to bed transfer was not attempted due to medical condition or safety concerns.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a review of Resident 3's Progress Notes dated 4/9/24 at 9:54 AM indicated Resident 3 was found on the floor on her back with a large laceration to her left elbow. The Resident 3 was transferred to GACH 1 via 911.</p> <p>During a concurrent interview with MDSC and record review on 5/8/24 at 6:39 PM, Resident 3's fall risk assessment dated [DATE] was reviewed and indicated Resident 3 was moderate risk for fall. The MDSC also stated, Resident 3's fall risk assessment dated [DATE] indicated the resident is moderate risk for fall and did not have history of fall. The MDSC stated the fall risk assessment for Resident 3 dated on 4/10/24 was not accurate because it indicated no history of fall, but resident fell on [DATE]. MDSC stated, the fall risk assessment needs to be accurate to ensure the facility is providing interventions according to the resident's needs.</p> <p>During a concurrent interview and record review on 5/8/24 at 6:39 PM of the Resident 3's care plan dated from 4/9/24 to 5/2/24 the MDSC stated no care plan was initiated after the fall incident on 4/9/24.</p> <p>During an interview on 5/8/24 at 9:45 PM with the Director of Nursing (DON), the DON stated, no investigation and report was done for Resident 2's fall on 4/25/24 and on 5/4/24. The DON also stated, no investigation was conducted for Resident 3's fall on 4/9/24. The DON also stated, both residents (Resident 2 and 3) did not have any injuries after the fall that is why she did not conduct any investigation as to how or why the residents fell .</p> <p>During a review of facility's policies and procedure (P&P) titled Safety and Supervision of Resident revised date 7/2017 indicated Our facility strives to make the environment as free from accident hazards as possible. Resident safety and supervision and assistance to prevent accidents are facility -wide priorities.</p> <p>During a review of facility's (P&P) titled Safety and Supervision of Resident revised date 3/2018 indicated for an individual who has fallen, the staff and practitioner will try to identify possible cause within the 24 hours of fall.</p> <p>During a review of facility's (P&P) titled Assessing fall and their cause revised date 3/2018 indicated the purpose of this procedure is to provide guidance for assessing a resident after a fall and to assist staff in identifying cause of fall. Review the care plans to assess for any special needs of the resident. The P&P also indicates that falls are leading cause of morbidity and mortality among the elderly in nursing homes.</p>		