STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055480	A. Building B. Wing	08/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Californian Pasadena Healthcare	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)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45523 Based on interview and record review, the facility failed to ensure one (1) of four (4) sampled residents (Resident 1) was not left unattended by facility staff while the resident is sitting on the bedside commode (a portable toilet) for long period of time. This deficient practice had a potential to result in skin breakdown and accidents that can lead to injury. Findings: During a review of the admission record indicated Resident 1 was originally admitted to the facility on [DATE] and readmitted on [DATE], with diagnoses that included but not limited to acquired deformities of left lower leg (any abnormality in the normal alignment of the leg occurring either within the bone or at the level of a joint), enterocolitis due to clostridium difficile (an inflammation of the colon caused by an overgrowth of the C. diff bacterium [a type of bacteria that can cause diarrhea and colitis, an inflammation of the colon]), abnormality of gait and mobility, severe protein-calorie malnutrition (a nutritional condition that occurs when someone doesn't consume enough protein and calories). During a review of Resident 1 Fall Risk assessment dated [DATE] indicated Resident 1 is low risk for fall. During a review of Resident 1's Minimum Data Set (MDS, a standardized assessment and care screening tool), dated 8/03/2024, indicated Resident 1 had intact cognition and needed substantial/maximal assistance (helper does more than half the effort) from the staff for the activities of daily living (personal care activities that are essential for independent living. They include basic tasks that people learn as children, like eating and walking) and was dependent (a person who depends on or needs someone or something for aid, support, favor) for toileting hygiene, showers, and dressing. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 1's Care Plan initiated 8/03/2024 indicated, At risk for falls secondary to antihypertensive (medicines that bring your blood pressure down in various ways), hypnotic (the use of medications to induce, extend, or improve sleep quality) use. Interventions indicated to answer call light in timely manner and assess and anticipate resident's needs such as toileting needs, comfort levels, and body positioning, etc. The care plan also indicated intervention to encourage resident to assume a standing position slowly, remind resident to walk slowly and rest adequately and keep environment free of clutter and safety hazards. During a review of Resident 1's Change in Condition document dated 8/12/2024 indicated, Female Caregiver (Certified Nurse Assistant [CNA] not specified) interviewed on 8/8/2024 at 3:35 pm and stated I saw the call light (a device used by patients to call for assistance from hospital staff) on, so I went to assist the patient (Resident 1). I assisted her to the bedside commode and told the daughter to use the call light when she was ready to get off the commode. I left the room to tend to another patient. I was not able to make it back to assist. During an interview with the facility Administrator (Admin) on 8/13/2024 at 7:46 am, Admin stated Family 1 talked to him about the Resident 1 being left sitting on the bedside commode for a long period of time on 8/8/2024. Admin stated, I made a grievance (an official statement of a complaint over something believed to be wrong or unfair) that same day. During an interview with CNA2 on 8/13/2024 at 8:05 am, CNA2 stated, I remember her (Resident 1) because I helped her that day (8/8/2024). CNA2 stated on 8/8/2024, Resident 1had the call light on, and went in to help the resident to the bedside commode. CNA2 also stated, CNA2 she instructed Resident 1 to use the call light when she was ready and left the resident's room. CNA2 also stated, after leaving Resident 1's room, CNA2 told the charge nurse that Resident 1 was left in the room while on the bedside commode and CNA2 got busy with other residents and did not go back to see if Resident 1 was done using the commode. During an interview with CNA1 on 8/13/2024 at 10:51 am, CNA1 stated, there was an incident with Resident 1, on 8/8/2024 when Resident 1 was placed on the bedside commode by another CNA and the CNA left the room while the resident is on the bedside commode. CNA1 stated, CNA1 was not aware at the time when Resident 1being placed on the bedside commode and was left without any supervisions by facility staff. During a concurrent interview with CNA1 on 8/13/2024 at 11:07 am, CNA1 stated, CNA2 left the patient on the bedside commode for a long period of time and from experience everyone takes a different time using the bedside commode, but 40 minutes is a long time to be on the bedside commode without facility staff's supervisions and/ or assistance and it was dangerous because the resident was not being monitored and the resident could have had a fall. CNA1 stated, the resident should not have been left alone while on the commode and should not have been left for long period of time. CNA1 stated this does place the resident at risk for accident such as fall. During an interview with the Director of Nursing (DON) on 8/13/2024 at 1:34 pm, per the DON, CNA2 just helped to put Resident 1 on the bedside commode and told the resident to use the call light when the resident was finished. The DON also stated, Resident 1 used the call light but we do not know for sure how long it was that she (Resident 1) was left sitting on the bedside commode. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview with CNA2 on 8/13/2024 at 1:45 pm, CNA2 stated she did not inform the residents assigned CNA (CNA1) that the resident was left on the bedside commode. CNA2 stated, she left the resident's room while Resident 1 while in the bedside commode. CNA2 stated I went and told my charge nurse that I left her (Resident 1) on the bedside commode. After that, I am not sure what happened or if the assigned CNA was made aware. CNA2 confirmed that she got busy and did not know for sure how long the Resident 2 was left sitting on the bedside commode without facility staff supervising the resident. During an interview with Charge Nurse (CN1) on 8/13/2024 at 1:57 pm, CN1 stated, Honestly, I do not really remember. I am not sure how long Resident 1was left on the bedside commode without facility staff present to supervise the resident in the room. During an interview with Family 1 on 8/13/2024 at 3:15 pm, Family 1 stated, There was a day last week when I went to visit my mom (Resident 1) at the facility, and she used the call light because she needed to use the bathroom. A CNA (unable to recall name) came in the room and assisted her to the bedside commode in the room. We used the call light and waited 10 to 15 minutes. I heard them say the call light was on and for someone to answer it, but nobody did. I ended up taking her (Resident 1) off the bedside commode myself and placed her back on the bed. When my watch hit the 40-minute mark from when we initially pressed the call light for assistance, I marched into the Administrators office and made him aware of what had happened. During a review of the facility's policy and procedure, Activities of Daily Living (ADLs), Supporting, revised 3/2018, indicated, Residents who are unable to carry out activities of daily living independently will receive the services necessary to maintain good nutrition, grooming and personal and oral hygiene. The policy also indicated appropriate care and services will be provided for residents who are unable to carry out ADLs independently, with the consent of the resident and in accordance with the plan of care, including appropriate support and assistance with elimination (toileting). During a review of the facility's policy and procedure titles Fall and Fall Risk Managing reviewed 3/2018 indicated, based on previous evaluations and current data, the staff will identify interventions related to the resident's specific risks and causes to try to prevent the resident from falling and to try to minimize complications from falling. The policy also indicated resident conditions that may contribute to the risk of falls include functional impairment.