STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055617	A. Building B. Wing	08/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pasadena Grove Health Center	1470 N Fair Oaks Ave Pasadena, CA 91103

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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49537 Based on observation, interview and record review, the facility failed to provide reasonable accommodation of needs for two of two sampled residents (Residents 1 and 4) by failing to ensure Residents 1 and 4's call lights (a device with a button or touchpad a resident uses to set off an alarm that flashes/rings to alert the facility staff the resident needs assistance) were within the resident's reach and the call lights were answered promptly as indicated in the facility's policy and procedure. This deficient practice had the potential for Residents 1 and 4 not to receive emergency and/ or necessary care or have a delay in care and services that could result in an accident such as fall and/ or skin breakdown. Findings: 1. During a review of Resident 1's Admission Record indicated the facility admitted the resident on 8/9/2024 with diagnoses that included complete atrioventricular block (a heart rhythm disorder that occurs when the heart's electrical conduction system can't transmit impulses from the atria to the ventricles causing the heart to beat more slowly than usual), presence of pacemaker (an artificial device for stimulating the heart muscle and regulating its contractions), right sided hemiplegia (severe or complete loss of strength or paralysis that makes it difficult or impossible to move the affected body parts) and hemiparesis (muscle weakness) due to cerebral infarction (stroke that occurs when an artery in the brain ruptures or becomes blocked, cutting off blood supply to the brain causing brain tissue to die), seizures (burst of uncontrolled electrical activity between brain cells that causes temporary abnormalities in muscle tone or movements [stiffness, twitching or limpness], behaviors, sensations or states of awareness), and abnormality of gait and mobility (a change in walking pattern caused by anything affecting the brain, spinal cord legs, or feet). During a review of Resident 1's History and Physical (H&P) dated 8/12/2024, indicated Resident 1 had the capacity to understand and make decisions. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 1's Minimum Data Set (MDS-a comprehensive assessment and care screening tool) dated 8/15/2024, indicated Resident 1 had moderate cognitive (ability to think, read, learn, remember, reason, express thoughts, and make decisions) impairment and required substantial or maximal assistance (helper lifts or holds trunk or limbs and provides more than half the effort) from facility staff with toileting hygiene. The MDS indicated the resident needed partial or moderate assistance (helper lifts, holds, or supports trunk or limbs but provides less than half the effort) from facility staff with shower/bathing, upper and lower body dressing and putting on/taking off footwear. During a review of Resident 1's care plan initiated on 8/15/2024, indicated resident had activities of daily living (ADL) self-care performance deficit. The care plan indicated to encourage resident to use bell to call for assistance. 2. During a review of Resident 4's Admission Record indicated the facility admitted the resident on 8/2/2024 with diagnoses including multiple sclerosis (disease in which the immune system eats away at the protective covering of nerves, the resulting nerve damage disrupts communication between the brain and the body), chronic pain syndrome (pain lasting months or years and happens in all parts of the body), and neuromuscular dysfunction of the bladder (the nerves and muscles don't work together very well that results in bladder not filling or emptying correctly). During a review of Resident 4's H&P dated 2/12/2024, indicated resident has the capacity to understand and make decisions. During a review of Resident 4's MDS dated [DATE], indicated Resident 4 had moderate cognitive impairment and needed substantial/maximal assistance from facility staff with toileting, shower/bathing, lower body dressing and putting on/taking off footwear. The MDS indicated the resident needed partial/moderate assistance with upper body dressing and personal hygiene. During an interview on 08/14/2024 at 10:15 AM with Resident 1 in his room, Resident 1 stated when calling the nurses using the call light, it was not answered right away, and it was a longer wait at nighttime usually more than five (5) minutes. Resident 1 stated he tried calling for staff on 8/10/2024 or 8/11/2024 (unable to recall exact date) during the night shift (11 PM to 7 AM) but could not find and reach his call light and so he requested his roommate to call using roommate's call light. Resident 1 also stated since he was admitted in the facility, there were three to four times he could not find his call light and made him frustrated. During a concurrent observation and interview on 8/14/2024 at 1:20 PM with Resident 4 in her room, observed resident lying in her recliner and watching television, Resident 4 stated on 8/12/2024, she was unable to reach her call light to call for assistance for diaper change. Resident 4 also stated, she called the nurses' station using her cellular phone, but nobody answered for more than 5 minutes, and she had to wait for a long time for someone to come. During a concurrent observation and interview on 8/15/2024 at 1:15 PM in Resident 4's room, observed Resident 4 in her recliner and one of the staff moved Resident 4 close to her bed then left the room. Observed Resident 4's call light was located at the head of the resident's bed and not within the resident's reach. Resident 4 reached for her television remote and stated she could not find her call light. At 1:30 PM, CNA 5 came in the room. Resident 4 asked her to find her call light and place it close to her. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 8/14/2024 at 2:03 PM with Certified Nurse Assistant (CNA 1), CNA 1 stated the policy was to answer call lights right away, within five minutes and ten-minute wait is not acceptable. CNA 1 also stated, call lights should also be within residents' reach and it is important to ensure resident's can always use it when they need to call for facility staff's help. CNA 1 also stated it is important for facility staff to answer the call light right away (within 5 minutes), if not, residents could get up and fall and hurt themselves, and resident could be having emergency or need medication. During an interview on 8/14/2024 at 3:03 PM with Registered Nurse Supervisor (RNS) at the nurse's station, RNS stated call lights should be within the resident's reach and should be answered by the facility staff right away, within three to five minutes and everyone should and/ or can answer the call light. During an interview on 8/14/2024 at 4:00 PM with the Director of Staff Development (DSD) at the Nurses' station, DSD stated licensed nurses and CNAs were to check that call lights and ensure they are within reach of residents during their rounds. DSD also stated he remembered the policy, that the call light should be answered right away, in three to five minutes and it is important to answer right away to find out what residents need or if they were having some emergency or needed assistance. DSD stated, if call light is not answered within three (3) to 5 minutes, residents could fall and injure themselves. During a review of the facility's Policy and Procedure titled Communication - Call System revised on 11/1/2017, indicated to provide a mechanism for residents to promptly communicate with nursing staff, call cords will be placed within the resident's reach in the resident's room and nursing staff will answer call bells promptly.

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49537 Based on observation, interview and record review, the facility failed to provide treatment and care for three of three sampled residents (Residents 1, 4, and 6) in accordance with professional standards of practice and the facility's policy and procedure by: 1. Failed to assess, document, and notify Resident 1's Attending Physician regarding the resident's pacemaker's (an artificial device for stimulating the heart muscle and regulating its contractions) dressing status. 2. Failed to check Resident 4 and 6 every two hours if they needed diaper change and/ or as needed when residents called to request for diaper change. These deficient practices had the potential to result in a delay of provision of necessary care and services to Residents 1, 4, and 6 which can lead to infection of Resident 1's surgical site and for Resident 4 and 6 to develop skin breakdown due to being left wet and/ or soiled for a long period of time. Findings: 1. During a review of Resident 1's Admission Record indicated the facility admitted the resident on 8/9/2024 with diagnoses that included complete atrioventricular block (a heart rhythm disorder that occurs when the heart's electrical conduction system can't transmit impulses from the atria to the ventricles causing the heart to beat more slowly than usual), presence of pacemaker, right sided hemiplegia (severe or complete loss of strength or paralysis that makes it difficult or impossible to move the affected body parts) and hemiparesis (muscle weakness) due to cerebral infarction (stroke that occurs when an artery in the brain ruptures or becomes blocked, cutting off blood supply to the brain causing brain tissue to die). During a record review of Resident 1's Order Summary Report as of 8/11/2024, indicated to monitor pacemaker site for swelling, redness, itching or pain every shift. During a review of Resident 1's History and Physical (H&P) dated 8/12/2024, indicated Resident 1 had the capacity to understand and make decisions. During a review of Resident 1's Minimum Data Set (MDS-a comprehensive assessment and care screening tool) dated 8/15/2024, indicated Resident 1 had moderate cognitive (ability to think, read, learn, remember, reason, express thoughts, and make decisions) impairment and required substantial or maximal assistance (helper lifts or holds trunk or limbs and provides more than half the effort) from facility staff with toileting hygiene. The MDS indicated the resident needed partial or moderate assistance (helper lifts, holds, or supports trunk or limbs but provides less than half the effort) from facility staff with shower/bathing, upper and lower body dressing and putting on/taking off footwear. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 8/14/2024 at 10:15 AM with Resident 1 in his room, Resident 1 stated he recalled calling the paramedics (highly trained health professionals who provide emergency medical care and transportation for patients) on 8/10/2024 or 8/11/2024 because he first needed assistance and wanted to call facility staff but unable to find his call light. Resident 1 stated he asked his roommate to call staff using too roommate's call button, but no one came (unable to recall for how long). Resident 1 also stated the reason he called the paramedics was due to his fear that when he accidentally removed the dressing (pad of gauze or cloth applied to a wound to promote healing and protect the wound from further harm such as infection) over his pacemaker, he had felt something hard like a small plate and thought that if sterile (free from bacteria or microorganisms) dressing needed to be replaced and if pacemaker was damaged, he would need to be taken to the emergency room . Resident 1 added the paramedics arrived (unable to recall exact date and time) in the room with the facility staff nurse and paramedics changed his dressing while facility staff nurse was present. During an interview on 8/14/2024 at 12:00 PM with Licensed Vocational Nurse/Charge Nurse (CLVN 1) at the south nurses' station, CLVN 1 stated she had not received endorsement that Resident 1 called the paramedics on 8/10/24 or 8/11/2024. During a concurrent interview and record review on 8/14/2024 at 12:24 PM with Registered Nurse Supervisor (RNS 1) at the North nurses' station, Resident 1's electronic chart and paper chart dated from 8/9/2024 to 8/14/2024 were reviewed. RNS 1 stated she cannot find documentation regarding paramedics responded to Resident 1's call and that Resident 1's pacemaker dressing was changed. RNS 1 stated she received verbal report of the paramedic call but did not know the reason, did not know if attending physician of Resident 1 was notified. RNS 1 stated there was no documentation that Resident 1 was assessed, treated, or evaluated by the facility staff. RNS 1 also stated it is important to document changes in condition, and to notify attending physician and resident representative so all members of the care team are aware. During an interview on 8/14/2024 at 3:05 PM with Minimum Data Set/Registered Nurse (MDS-RN), MDS-RN stated the facility did not have any documented evidence, there were no documentation in Resident 1's paper chart and none in the resident's electronic chart dated form 8/9/2024 to 8/14/2024 regarding the paramedic call incident, Resident 1's pacemaker dressing status and change, and that the resident's attending physician was notified. During a concurrent interview and record review on 8/15/2024 at 2:47 PM with the Administrator (ADM), the Interdisciplinary Team (IDT) meeting dated 8/12/2024 was reviewed. ADM stated the IDT meeting notes for Resident 1 did not include regarding when the paramedics came to respond to Resident 1's call, did not include regarding the resident's pacemaker dressing was changed and that the resident's attending physician was notified regarding the changes of condition. During a record review of the report from paramedics/ City Fire Department, dated 8/10/2024, indicated incident occurred on 8/10/2024 at 4:31 AM, paramedics arrived at the facility at 4:36 AM. The report also indicated Resident 1 had no medical complaint but was concerned that his bandage (pacemaker dressing) on his left upper chest had fallen off. The report indicated, paramedics reassured resident that his wound was not open, cleaned site of bandage with antiseptic wipe and asked staff to apply new bandage if needed. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a record review facility's Policy and Procedure (P&P) titled Documentation - Nursing revised on 11/1/2017, indicated its purpose was to provide documentation of resident status and care given by nursing staff, nursing documentation will be concise, clear, pertinent, and accurate. The P&P also indicated, treatments completed and documented as per physician's order and alert charting is documentation done to track a medical event for a period of 72 hours of longer, events may include suspected or actual change in condition. During a record review of facility's P&P titled Change of Condition Notification revised on 11/1/2017, indicated the licensed nurse will notify the resident's attending physician when there is an incident/accident involving the resident, will be notified timely, and document date, time, and pertinent details of the incident and the subsequent assessment in the nursing notes. The P&P also indicated the documentation should also include the time the attending physician was contacted, the method by which he was contacted, the response time, and whether orders were received. In addition, the P&P indicated the plan of care is to be updated to reflect the resident's current status, the incident and brief details in the 24-hour report and complete an incident report per facility policy. A review of the facility's P&P titled Care and Services, revised 11/1/2017, indicated the licensed nurse or designee documents and notifies the resident's physician and responsible party of: a. change in condition, including progress and/or decline in physical or mental function; b. unusual circumstances. 2. During a review of Resident 4's Admission Record indicated the facility admitted the resident on 8/2/24 with diagnoses including multiple sclerosis (disease in which the immune system eats away at the protective covering of nerves, the resulting nerve damage disrupts communication between the brain and the body), chronic pain syndrome (pain lasting months or years and happens in all parts of the body), and neuromuscular dysfunction of the bladder (the nerves and muscles don't work together very well that results in bladder not filling or emptying correctly). During a review of Resident 4's H&P dated 2/12/24, indicated resident has the capacity to understand and make decisions. During a review of Resident 4's MDS dated [DATE], indicated Resident 4 had moderate cognitive impairment and needed substantial/maximal assistance from facility staff with toileting, shower/bathing, lower body dressing and putting on/taking off footwear. The MDS indicated the resident needed partial/moderate assistance with upper body dressing and personal hygiene. During a review of Resident 6's H&P dated 6/6/2024, indicated Resident 6 has the capacity to understand and make decisions. During a review of Resident 6's Admission Record indicated the facility initially admitted the resident on 4/10/2019 and readmitted on [DATE] with diagnoses that included chronic obstructive pulmonary disease (COPD-a common lung disease that damages airways and makes its hard to breathe), abnormalities of gait and mobility, paranoid schizophrenia (a pattern of behavior where a person feels distrustful and suspicious of other people and acts accordingly), and osteoarthritis (degeneration of joint cartilage and the underlying bone, it causes pain and stiffness especially in the hip, knee and thumb joints). (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 6's MDS dated [DATE], indicated resident had moderate cognitive impairment and needed substantial/maximal assistance with toileting, needed partial/moderate assistance with shower/bathing, dressing upper and lower body dressing and putting on and taking off footwear, and needed supervision with eating and oral hygiene. During a review of Resident 6's Care plan initiated on 2/27/2020 and revised 12/12/2023, indicated resident is at risk for impaired skin integrity related to bladder and bowel incontinence (lack of voluntary control over urination or defecation). The care plan indicated intervention to prevent skin breakdown included cleaning after each episode of incontinence and keeping resident clean, dry, and comfortable at all times. During an interview on 8/14/2024 at 1:20 PM with Resident 4 in her room, observed resident lying in her recliner and watching television, Resident 4 stated on 8/12/2024 at night shift (from 11:00 PM- 7:00 AM), she was unable to reach her call light to call for assistance for diaper change, she called the nurses' station using her cellular phone, but nobody answered so she waited until someone came (resident unable to recall how long she waited). Resident 4 also added on 8/9/2024 around evening shift (from 3:00 PM to 11:00 PM), and 8/12/2024 during the night shift, she did not get her diaper changed for 12 hours. During a record review of Resident 4's Documentation Survey Report for the month of August 2024, there was no documentation for personal hygiene was done on 8/9/2024 during the evening shift and toilet use on 8/12/2024 for night shift. During an interview on 8/14/2024 at 2:03 PM with Certified Nurse Assistant (CNA 1), CNA 1 stated she was unable to attend to other residents on several occasions because the residents assigned to her were more than the number of residents that should be assigned per CNA especially when other staff call off and nobody replaced the CNA. CNA added she was unable to change diapers or gowns right away or reposition the residents needed for repositioning every two hours or when a resident calls, it was important to change wet diapers right away to prevent skin irritation, reposition to prevent skin injury. During an interview on 8/14/2024 at 2:20 PM with CNA 2, CNA 2 stated they were short staffed four to five times in a week, they were assigned 11-13 residents per CNA. CNA 2 added it was difficult to take care of all her assigned residents such as answering their call lights, checking residents every 2 hours to ensure if they need diaper change, repositioning residents in bed, and getting residents out of bed and/ or back to bed. CNA 2 stated it was important to change diapers and/ or reposition residents every 2 hours to prevent skin irritation and injury and taking care of the resident's needs make the residents satisfied with the care. During an interview on 8/15/2024 at 11:54 AM with Resident 6 in her room, Resident 6 stated she used her call light to call staff to change her wet diaper, but it had happened several times that she needed to wait an hour to be changed. Resident 6 added she cannot recall the exact dates and times, but it happened most of the time, morning, afternoon, and late evening. Resident 6 further stated it had upset her, especially when she was in the activity room, and she had asked for diaper change and was told later after the activity. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review on 8/15/2024 at 12:20 PM with Director of Staff Development (DSD), Staffing assignment for 8/11/2024 day shift was reviewed. DSD stated they were short staffed on 8/11/2024 and needed one to two more CNAs for day shift (7:00 AM to 3:00 PM). DSD also stated, on 8/11/2024 day shift, five CNAs each had 12 residents assigned, 1 CNA was assigned 4 residents occupying one room as one resident needed 1:1 (one-to-one) monitoring for elopement. DSD added that goals were to give the best care, prevent harm or injury to their residents and when they were short staffed, call lights were not answered right away, residents were not turned every two hours, residents' diapers were not changed when already soiled and those could lead to accidents, pressure, or skin breakdown respectively. During an interview on 8/15/2024 at 2:47 PM with the Administrator (ADM), ADM stated they were short staffed, and needed to fill for can positions especially for the weekend. ADM also stated he was not aware that they were short staffed of CNAs on 8/11/2024 during day shift and CNAs each had 12 residents. ADM also stated that it is important to have enough staff to ensure residents' needs are met. During a record review of the facility's P&P titled Positioning and Body Alignment revised 11/1/2017, indicated to change the resident's position every two hours or as otherwise indicated or ordered by the Attending Physician. During a review of the facility's P&P tilted Resident Rights - Quality of Life revised 11/01/2017, indicated facility staff provides care and services that ensure that resident's abilities in activities of daily living, including hygiene, mobility, elimination, dining, communication, speech, language and other methods of communication do not diminish while in the care of the facility, except when unavoidable as evidenced by clinical condition. The P&P also indicated that demeaning practices and standards of care that compromise dignity are prohibited. The P&P also indicated facility staff will promote dignity and assist residents as needed by promptly responding to resident's request for toileting assistance.