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	08/16/2024

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45456 Based on observation, interview, and record review, the facility failed to develop and/or implement an individualized resident-centered care plan (a care plan that prioritizes the unique health needs and desired outcomes of the resident) for one (1) of four (4) sampled residents (Residents 1) to address inappropriate behavior and wandering as indicated on the facility policy. This failure had the potential for Resident 1 not to receive interventions specific to the resident's needs, which could result in injury and harm to Resident 1 and other residents. Findings: During a review of Resident 1's Admission Record, the Admission Record indicated the resident was admitted to the facility on ,d+[DATE]//2024. Resident 1 's diagnoses included adult failure to thrive (insufficient weight gain or inappropriate weight loss), chronic obstructive pulmonary disease (COPD, a chronic inflammatory lung disease that causes obstructed airflow from the lungs), and hypertension (high blood pressure). During a review of Resident 1's History and Physical (H&P), dated 7/8/2024, the H&P indicated Resident 1 has the capacity to understand and make decision. During a review of Resident 1's Admit/ Readmit Screener, dated 8/14//2024, the screener indicated Resident 1 had an intact cognitive skill (mental action or process of acquiring knowledge and understanding) for daily decision making. Resident 1 needed supervision or touching assistance (helper provides verbal cues, touching and contact guard assistance as resident completes the activity) in bed mobility, transfer, dressing, eating, toilet use, personal hygiene, walk in room and in corridor and locomotion on and off unit. During an interview with the Licensed Vocational Nurse 1 (LVN 1) on 8/16/2024 at 1:10 PM, LVN 1 stated she received the report from the transferring facility that Resident 1 displays inappropriate behavior. LVN 1 stated according to the report, Resident 1 likes to make inappropriate comments to female staff. (continued on next page)

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

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with the MDS Nurse (MDSN) on 8/16/24 at 2:50 PM, MDSN stated Resident 1 was not observed with inappropriate behavior during admission to the facility so a care plan was not developed. MDSN stated Resident 1 was wandering in the morning of 8/15/2024 so a care plan for wandering should have been developed. During a concurrent record review of Resident 1's Elopement Risk Assessment, dated 8/14/2024 and interview with the Director of Nursing (DON) on 8/16/2024, at 3:08 PM, the DON stated, Resident 1's score was a six (6) which meant low risk because there were no episodes of wandering. The DON stated Resident 1 had episodes of wandering around the facility on 8/15/2024 so the Elopement Risk Assessment should have been redone to indicate Resident 1 as high risk for wandering. The DON stated since Resident 1 is high risk for wandering, Resident 1 should have been monitored and supervised according to policy. During a review of the facility's Policy and Procedure (P&P) titled, Care Planning, revised 10/24/2022, the P&P indicated a licensed nurse will initiate the care plan, and the plan will be finalized in accordance with Omnibus Budget Reconciliation Act (OBRA, also known as the Nursing Home Reform Act of 1987, has dramatically improved the quality of care in nursing homes over the last twenty years by setting federal standards of how care should be provided to residents) / MDS guidelines and updated as indicated for change in condition, onset of new problems, resolution of current problems, and as deemed appropriate by clinical assessment and judgement on an as needed bases. The Baseline Line Care Plan will be updated to reflect changes in the residents' condition or needs occurring prior to the development of the Comprehensive Care Plan.

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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** 45456 Based on observation, interview, and record review, the facility failed to provide adequate supervision in accordance with the facility policy for one (1) of four (4) sampled residents (Resident 1) who was reported to exhibit inappropriate behavior and was observed with episodes of wandering. This deficient practice resulted to Resident 1 wandering into another resident's room with an allegation from the other resident (Resident 2) of inappropriate touching. This deficient practice also had the potential for Resident 1 to sustain injury and harm. Findings: During a review of Resident 1's Admission Record indicated the resident was admitted to the facility on , d+[DATE]//2024. Resident 1 's diagnoses included adult failure to thrive (insufficient weight gain or inappropriate weight loss), chronic obstructive pulmonary disease (COPD, a chronic inflammatory lung disease that causes obstructed airflow from the lungs), and hypertension (high blood pressure). During a review of Resident 1's History and Physical (H&P), dated 7/8/2024, the H&P indicated Resident 1 has the capacity to understand and make decision. During a review of Resident 1's Admit/ Readmit Screener, dated 8/14//2024, the screener indicated Resident 1 had an intact cognitive skill (mental action or process of acquiring knowledge and understanding) for daily decision making. Resident 1 needed supervision or touching assistance (helper provides verbal cues, touching and contact guard assistance as resident completes the activity) in bed mobility, transfer, dressing, eating, toilet use, personal hygiene, walk in room and in corridor and locomotion on and off unit. During a review of Resident 2's Admission Record, the Admission Record indicated the resident was admitted to the facility on [DATE]. Resident 2's diagnoses included quadriplegia (condition in which both the arms and legs are paralyzed and lose normal motor function), anxiety disorder (a disorder characterized by nervousness characterized by a state of excessive uneasiness and apprehension, typically with compulsive behavior or panic attacks), and generalized muscle weakness. A review of Resident 2's Minimum Data Set (MDS, a standardized assessment and care-screening tool), dated 7/12/2024, indicated Resident 2 had an intact cognitive (mental action or process of acquiring knowledge and understanding) skill for daily decision making. The MDS indicated Resident 2 was dependent (helper does all of the effort, Resident does none of the effort to complete the activity) in eating, oral hygiene, toileting hygiene, shower/bathe self, upper/lower body dressing, putting on/ taking off footwear, roll left and right, sit to lying, and lying to sitting on side of bed. During an interview with Resident 2 on 8/16/2024 at 11:07 AM, Resident 2 stated, The facility does not watch these crazy residents. They run up and down the hallway by themselves. I can not blame the resident (Resident 1) because he is a crazy guy. Resident 2 stated the facility could have supervised Resident 1. (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 review of Resident 1's Progress notes, dated 8/16/2024 timed at 12:20 AM, the progress notes indicated Resident 2 stated Resident 1 went inside her room and touched Resident 2's body inappropriately. It indicated Licensed Vocational Nurse 1 (LVN 1) noticed Resident 1 on 8/15/2024 at 9 PM come out of Resident 2's room with a box of tissue. It also indicated Resident 1 stated Resident 2 wiped her eyes with a tissue then touched her hair, and placed the tissue on her stomach and left the room. During an interview with the LVN 1 on 8/16/2024 at 12:49 PM, LVN 1 stated, after 9PM, I noticed Resident 1 was around the nurse station and he was just walking around by himself with his front wheel walker and then he went into Resident 2's room. It was not very long, about 2 minutes, and I saw him walking out of the room with a box of tissue. During an interview with the LVN 1 on 8/16/2024 at 1:10 PM, LVN 1 stated she received the report from the transferring facility that Resident 1 displays inappropriate behavior. LVN 1 stated according to the report, Resident 1 likes to make inappropriate comments to female staff. During an interview with the MDS Nurse (MDSN) on 8/16/24 at 2:50 PM, MDSN stated Resident 1 was not observed with inappropriate behavior during admission to the facility so a care plan was not developed. MDSN stated Resident 1 was wandering in the morning of 8/15/2024 so a care plan for wandering should have been developed. During a concurrent record review of Resident 1's Elopement Risk Assessment, dated 8/14/2024 and interview with the Director of Nursing (DON) on 8/16/2024, at 3:08 PM, the DON stated, Resident 1's score was a six (6) which meant low risk because there were no episodes of wandering. The DON stated Resident 1 had episodes of wandering around the facility on 8/15/2024 so the Elopement Risk Assessment should have been redone to indicate Resident 1 as high risk for wandering. The DON stated since Resident 1 is high risk for wandering, Resident 1 should have been monitored and supervised according to policy. During a review of the facility's policy and procedure (P&P) titled, Safety of Residents, revised on 11/1/2017, indicated to provide a safe environment for residents and facility staff. Upon admission, residents will be monitored for behavioral triggers including, but not limited to increased pacing or wandering. During a review of the facility's P&P titled, Elopement Risk Reduction Approaches, revised in 11/2017, indicated to ensure residents are able to move freely, are monitored and remain safe. Accompany wandering residents on their journey when supervision is required to ensure safety or encourage a meaningful, alternate activity.

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that a working call system is available in each resident's bathroom and bathing area. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45456 Based on observation, interview and record review, the facility failed to ensure call light (used in healthcare facilities as an alerting device for nurses or other nursing personnel to assist a resident when in need) was within reach and failed to provide an adaptive call light (specialty call light that will fit the resident's need if unable to use the regular call light with a call button) for one (1) of four (4) sampled residents (Resident 2) as indicated in the facility's policy and procedure and care plan. This deficient practice had the potential not to meet Resident 2's needs and preference. Findings: During a review of Resident 2's Admission Record, the Admission Record indicated the resident was admitted to the facility on [DATE]. Resident 2's diagnoses included quadriplegia (is the condition in which both the arms and legs are paralyzed and lose normal motor function), anxiety disorder (a disorder characterized by nervousness characterized by a state of excessive uneasiness and apprehension, typically with compulsive behavior or panic attacks), and generalized muscle weakness. During a review of Resident 2's Minimum Data Set (MDS, a standardized assessment and care-screening tool), dated 7/12/2024, the MDS indicated Resident 2 has intact cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decision making. The MDS indicated Resident 2 was dependent (helper does all of the effort, Resident does none of the effort to complete the activity) in eating, oral hygiene, toileting hygiene, shower/bathe self, upper/lower body dressing, putting on/ taking off footwear, roll left and right, sit to lying, and lying to sitting on side of bed. During a review of Resident 2's Care Plan (CP) dated 6/24/2024, the Care Plan indicated the Resident 2 is at risk for limited physical mobility related to quadriplegia. The care plan interventions included using phone to call the facility tor RN Supervisor's phone to call for help in substitute for the use of call light. During a concurrent observation and interview with Resident 2 on 8/16/2024 at 11:17 AM, Resident 2's call light was tied on the left bed rail (rails or board attached to the side of the bed which is used to prevent a fall or help residents to pull themselves up or turn in bed), dangling on the side of the bed and not within Resident 2's reach. Observed Resident 2's call light has to be pressed on the call button to be activated. Resident 2 stated, I cannot use this call light because I am paralyzed, I cannot use my fingers. I need something that I can blow air (padcall, ideal for residents who have limited hand movement and can be activated by blowing air on it) to. To ask assistance from the staff, I have to yell just to call for help, but they usually never hear me, and they never check on me often. I do not have a direct number in the nurse station. (continued on next page)

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent observation in Resident 2's room and interview with the Director of Nursing (DON) on 8/16/2024, at 11:59 AM, Resident 2's call light was on the same position tied on the left bed rail, dangling on the side of the bed and not within Resident 2's reach. The DON removed the call light from being tied and placed it next to Resident 2 left hand. Resident 2 confirmed to the DON that she was not able to use the call light with call button and stated, I cannot use my hands. The DON stated, we will replace it with sensor. Resident 2 stated, I cannot use that sensor because I cannot turn my face because I have nerve damage. The DON asked Resident 2 how she calls for help. Resident 2 stated, I call 911 to call for help because I do not have the number for the nurse station to be able to call the facility. The DON stated, Resident 2 should have been provided with an adaptive call light to ensure resident can use it to call facility staff when she needs help. During an interview with Certified Nursing Assistant 2 (CNA 2) on 8/16/2024 at 3:37 AM, CNA 2 stated, Resident 2 calls for help by yelling Nurse! Nurse! We can hear her call for help and the charge nurse calls us. Call light is important because Resident 2 cannot help herself because she is total care and relying on us for help and needs. I will feel worthless on her situation if she cannot use the call light and ask for assistance because she cannot move all her extremities. During a review of the facility's Policy and Procedure (P&P) titled, Communication- Call System, revised 11/1/2017, the P&P 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. An adaptive call bell (call light) (e.g. flat pad (activated by slight pressure from the hand, arm or body and can be positioned under patient's chin) call cord, hand bell, etc. will be provided to a Resident per Resident's needs. During a review of the facility's P&P titled, Resident Rights- Accommodation of Needs revised 11/1/2017, the P&P indicated the facility's environment is designed to assist the Resident in achieving independent functioning and maintaining the resident's dignity and well-being. Residents' individual needs and preference, including the need for adaptive devices and modifications to the physical environment, are evaluated upon admission and reviewed on an ongoing basis.