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	10/28/2024

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 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely, quality laboratory services/tests to meet the needs of residents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44636 Based on interview and record review, the facility failed to obtain urine sample for urine analysis as indicated in the physician's order for one of two sampled residents (Resident 1). This deficient practice had the potential to delay necessary care and services, not optimized for the best possible health outcomes and the potential to cause a negative impact on the resident's overall physical well-being. Findings: During a record review of Resident 1's Admission Record indicated Resident 1 was initially admitted to the facility on [DATE] and readmitted on [DATE], with diagnoses of quadriplegia (paralysis of all four limbs), urinary tract infection (UTI, a common bacterial infection that affects the urinary tract, which includes the bladder, kidneys, and urethra), and chronic kidney disease (gradual loss of kidney damage where kidneys cannot filter the blood the way they should). During a review of Resident 1's care plan, dated 6/24/2024, the care plan indicated Resident 1 had an indwelling catheter (a flexible tube that's put into bladder to drain urine (pee) into a drainage bag). The care plan interventions were to monitor/record/report to physician for signs and symptoms of UTI: pain, burning, blood-tinged urine, cloudiness, no output, deepening of urine color, increased pulse, increased temperature, urinary frequency, foul smelling urine, fever, chills, altered mental status, change in behavior, and change in eating patterns. During a review of Resident 1's Minimum Data Set (MDS, a federally mandated resident assessment and tool), dated 9/23/2024, the record indicated the resident's cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decision making were intact. The MDS indicated Resident 1 was dependent (helper does all of the effort, resident does none of the effort to complete the activity, or the assistance of two or more helpers is required for the resident to complete the activity) with toileting hygiene, shower/bathe self, and rolling to the left and right. The MDS also indicated Resident 1 had an indwelling catheter. During a review of Resident 1' s Physician Order Summary Report, dated 10/21/2024, the record indicated the physician ordered a urinalysis (UA, a physical, chemical, and microscopic examination of urine) with culture and sensitivity (C&S, a laboratory test used to identify the presence of bacteria in a sample and determine their susceptibility to antibiotics) for hematuria (blood in the urine). (continued on next page)

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

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F 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 1's Change of Condition (COC, tool used by health care professionals when communicating about critical changes in a resident's status), dated 10/21/2024, the record indicated the indwelling catheter was noted with hematuria. The record indicated the physician ordered a UA with C&S for hematuria. During a review of Resident 1's Nurses Notes, dated 10/21/2024, the record indicated Resident 1 was on monitoring for hematuria and slight hematuria was still noted. During a review of Resident 1's Nurses Notes, dated 10/22/2024, the record indicated Resident 1 was on monitoring for hematuria and some hematuria was noted. During an interview on 10/28/2024 at 12:02 PM with Registered Nurse (RN), RN stated there was a COC on 10/21/2024 for hematuria. RN stated Resident 1 had recurrent UTIs. RN stated the COC indicated the physician ordered a UA and C&S for the hematuria on 10/21/2024. During an interview on 10/28/2024 at 12:47 PM with Licensed Vocational Nurse (LVN), LVN stated she completed a COC for hematuria on 10/21/2024. LVN stated the Treatment Nurse (TXN) had informed LVN that she noticed the physician of Resident 1's hematuria and the physician ordered a UA with C&S on 10/21/2024. LVN stated she did not obtain the UA from Resident 1. LVN stated she did not know if TXN obtained Resident 1's UA. LVN stated she did not follow up with Resident 1's physician's order for the UA the following day (10/22/2024). During an interview on 10/28/2024 at 1:48 PM with the Minimum Data Set Registered Nurse (MDSRN), MDSRN stated there were no UA laboratory results ordered by the physician on 10/21/2024. MDSRN stated there was an order for Resident 1's UA on 10/21/2024, but the UA was not sent out to the laboratory. MDSRN stated he did not know why the UA was not picked up by the laboratory technician. A concurrent record review of the requisition forms with MDSRN, MDSRN stated staff did not fill out a laboratory form for the UA. The MDSRN stated there was no form in the chart and there was no form next to the nursing station where specimens were collected and placed. MDSRN stated there was also no documentation that the laboratory was called to collect the UA. During an interview on 10/28/2024 at 2:36 pm with the Director of Nursing (DON), the DON stated the staff must carry out the physician order when staff received the order from the physician. The DON stated the staff who received the order from the physician needed to obtain the urine sample, complete the laboratory requisition form, and complete the documentation. The DON stated the requisition form was printed out and attached to the specimen. The DON stated once the laboratory requisition form was completed, the laboratory technician would collect the specimen the following morning. The DON stated the importance of carrying out the physician's order was to determine if Resident 1 had a UTI and what type of bacteria the resident had since Resident 1 had a change of condition. During a concurrent review record of the online order requisition forms and interview with the DON and RN on 10/28/2024 at 2:46 PM, RN stated there was no order placed for laboratory to pick up Resident 1's UA from 10/21/2024 to 10/28/2024. (continued on next page)

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F 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility's Policy and Procedure titled, Laboratory, Diagnostic and Radiology Services, revised 11/1/2017, the record indicated laboratory, diagnostic and radiology services will be coordinated pursuant to an order by a physician in accordance with the scope of practice under state law. The facility is responsible for the quality and timeliness of services provided by the laboratory, diagnostic or radiology provider. Laboratory services ordered will be documented on the 24-Hour Report or electronic health record, to ensure that services are coordinated and results are received timely.