STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056316	A. Building B. Wing	04/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Camellia Gardens Care Center	1920 N. Fair Oaks Avenue 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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48152 Based on observation, interview and record review, the facility failed to ensure one of three sampled residents (Resident 1), had a safe and homelike environment by inserting two pillows and a wedge (triangular piece of foam cushion used to add elevation [to a portion of the body part]) between Resident 1's mattress and bedframe. These failures had the potential to result in an unsafe, and uncomfortable environment for Resident 1's and violation of right to a dignified existence. Cross reference with F689. Findings: A review of Resident 1's Admission Record indicated Resident 1 was admitted to the facility on [DATE] with diagnoses that include seizures (a sudden disruption of the brain's normal electrical activity accompanied by altered consciousness and/or other neurological and behavioral manifestations), Parkinson's disease (a disorder of the central nervous system that affects movement, often including involuntary shaking or movements and slowing of voluntary movements) without dyskinesia (impairment of voluntary movement, bipolar (a mental illness that causes unusual shifts in mood, energy, and concentration) and schizophrenia (a severe mental illness that causes disturbed or unusual thinking, loss of interest in life, and strong or inappropriate emotions). A review of Resident 1's Minimum Data Set (MDS - a standardized resident assessment care screening tool) dated 4/2/2024, indicates Resident 1 has a severe impairment (difficulty with or unable) to make decisions, learn, remember things. The MDS also indicated Resident 1 dependent (staff does all the effort) for showering, transferring from bed to chair/chair to bed and standing and maximal assistance (staff does more than half the effort) for oral hygiene, toileting and rolling left to right in bed. A review of Resident 1's History & Physical (H&P) indicated Resident one has a changing ability to understand and make decisions. During an observation on 4/3/2024 at 12:29PM at Resident 1's bedside, Resident 1 was observed lying in bed and two pillows (one on the left side and right side of the foot of the bed) and a wedge inserted between the mattress and bed frame. (continued on next page)

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

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent observation and interview on 4/3/2024 at 12:41 PM, at Resident 1's bedside with Certified Nurse Assistant (CNA) 1, Resident 1 was observed lying in bed two pillows (one on the left side and right side of the foot of the bed) and wedge inserted between the mattress and bed frame. CNA 1 also stated when he started his shift and assisted Resident 1 with care at 7:10 AM (on 4/3/2024), the two pillows and wedge were already placed between Resident 1's mattress and bedframe and he did not remove the pillows and wedge. During a concurrent observation and interview on 4/3/2024 at 1 PM with the DON at Resident 1's bedside, Resident 1's was observed lying in bed with two pillows (one on the left side and right side of the foot of the bed) and wedge inserted between the foam mattress and bed frame at the foot of the bed. The DON stated the 2 pillows and wedge should not be there between the mattress and bedframe because it is causing an elevation of the feet that limits him from moving and creates a safety risk of aspirating (a condition in which food, liquids, saliva, or vomit is breathed into the airways). The DON also stated having the pillows and wedge under the mattress can be unsafe and uncomfortable for the resident. During a concurrent interview and record review on 4/4/2024 at 11:59AM with the DON, the DON Resident 1's medical chart (electronic and physical) was reviewed. The DON stated, there was no documented evidence that: a. An assessment was completed to ensure the safety of Resident 1 prior to during the use of pillows and wedge between Resident 1's mattress and bedframe. b. An interdisciplinary (IDT) team meeting was completed for the use of pillows/wedge between Resident 1's mattress and bedframe. c. Nursing assessments and monitoring were completed prior to and during the use two pillows/wedge between Resident 1's mattress and bedframe. During a review of facility's P&P titled Resident's Rights revised 12/2016, indicated staff are to treat all residents with kindness, respect and dignity and residents have the basic rights to a dignified existence and to be treated with respect, kindness, and dignity. During a review of facility's policy and procedure (P&P) titled Homelike Environment revised 2/2021, indicated facility is to provide residents with a safe, clean, comfortable, and homelike environment and to minimize (to extent possible) characteristics of the facility that reflect a depersonalized setting such as bed alarms.

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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 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** 48152 Based on observation, interview, and record review, the facility failed to provide an environment free of accident hazards for one of three sampled residents (Resident 1), when facility: 1. Failed to provide padded bilateral (left and right side) siderails (a barrier attached to side of the bed [can be head of bed, or food of the bed or full length of the bed) while Resident 1 was in bed on as indicated in Resident 1's care plan and doctor's order. 2. Failed to follow the correct use of mattress for Resident 1's as indicated in manufacturer's manual. Resident 1 lying in bed with two pillows and a wedge (triangular piece of foam cushion used to add elevation [to a portion of the body part]) in between the mattress and bed frame. These failures placed Resident 1 at risk for physical harm and injury due to safety hazards. Findings: A review of Resident 1's Admission Record indicated Resident 1 was admitted to the facility on [DATE] with diagnoses that include seizures (a sudden disruption of the brain's normal electrical activity accompanied by altered consciousness and/or other neurological and behavioral manifestations), Parkinson's disease (a disorder of the central nervous system that affects movement, often including involuntary shaking or movements and slowing of voluntary movements) without dyskinesia (impairment of voluntary movement, bipolar (a mental illness that causes unusual shifts in mood, energy, and concentration) and schizophrenia (a severe mental illness that causes disturbed or unusual thinking, loss of interest in life, and strong or inappropriate emotions). A review of Resident 1's Minimum Data Set (MDS - a standardized resident assessment care screening tool) dated 4/2/2024, indicates Resident 1 has a severe impairment (difficulty with or unable) to make decisions, learn, remember things. The MDS also indicated Resident 1 dependent (staff does all the effort) for showering, transferring from bed to chair/ chair to bed and standing and maximal assistance (staff does more than half the effort) for oral hygiene, toileting and rolling left to right in bed. A review of Resident 1's History & Physical (H&P) dated 3/27/2024, indicated Resident one has a changing ability to understand and make decisions. A review of Resident 1's Seizure Disorder Care Plan revised 3/29/2024, indicated staff are to have bilateral upper padded side rails up and locked while Resident 1 is in bed for mobility, positioning, and for safety. A review of Resident 1's Medication Administration Record (MAR) dated 4/1/2024 - 4/2/2024, indicated staff are to monitor of use of bilateral upper padded side rails three times a day, during every shift. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1. During an observation on 4/3/2024 at 12:29 PM at Resident 1's bedside, Resident 1's bed was observed with bilateral upper siderails in up position, unpadded. During a concurrent observation and interview on 4/3/2024 at 1 PM with the Director of Nursing (DON), at Resident 1's bedside, Resident 1's bed was observed with bilateral upper siderails in up position, unpadded. The DON stated there was no padding on either side of the upper side rail. During a concurrent interview and record review on 4/3/2024 at 1:10PM with DON, Resident 1's Order Summary Report dated 4/4/2024 was reviewed. The order summary indicated an order for bilateral upper padded side rails to Resident 1's bed for seizure precaution (safety measure). DON stated there should be padding on the upper side rails as indicated in the order and not having the padding puts Resident 1 at risk for bumping his head and limbs and experience [negative] neurological changes (symptoms include paralysis, muscle weakness, poor coordination, loss of sensation, seizures, confusion, pain and altered levels of consciousness). 2. During an observation 4/3/2024 at 12:29 PM at Resident 1's bedside, Resident 1 was observed lying in bed with two pillows (one on the left side and right side of the foot of the bed) and a wedge cushion between the mattress and bed frame. During a concurrent observation and interview at 4/3/2024 at 12:41 PM with Certified Nurse Assistant (CNA) 1 at Resident 1's bedside, Resident 1 was observed lying in bed with two pillows (one on the left side and right side of the foot of the bed) and a wedge cushion between the mattress and bed frame. CNA 1 stated there were two pillows and cushion between Resident 1's mattress and bedframe. CNA 1 stated when he started his shift and assisted Resident 1 with care at 7:10AM (on 4/3/2024), the two pillows and wedge were already placed between Resident 1's mattress and bedframe and he did not remove them. During a concurrent observation and interview on 4/3/2024 at 1 PM with DON at Resident 1's bedside, Resident 1's bed was observed with two pillows and a wedge cushion inserted between the foam mattress and bed frame at the foot of the bed. The DON stated the wedge and pillows should not be under the mattress for safety purposes. During a concurrent observation and interview on 4/3/2024 at 4:05 PM with Maintenance Director (MD), at Resident 1's bed, the mattress tag was observed. MD stated Resident 1's current mattress on the bed is a prime mattress from Mattress Company 1. A review of the Mattress Company 1 Owner's Manual (undated) indicated improper use of this product or not following warnings and/or directions of use can result in damage, injury or even death. The manual also indicated for the mattress to be placed on the bed frame and secured as necessary. A review of the facility's policy and procedure (P&P) titled Safety Precautions, Nursing Services revised 12/2009, indicated staff shall follow safety precautions established by the facility when providing nursing care and services including reporting all unsafe conditions to supervisor as soon as possible. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the facility's P&P titled Hazardous Areas, Devices and Equipment, revised 7/2017, defined a hazard as anything in the environment that has the potential to cause injury including devices and equipment that are improperly used. The P&P also indicated all hazardous devices and equipment in the facility will be identified and addressed appropriately to ensure resident safety and mitigate (lessen) accident hazards to the extent possible.