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	01/24/2025

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48152 Based on observation, interview and record review, the facility failed to ensure two of three sampled residents (Resident 1 and 2), were kept clean and provided appropriate care for Activities of Daily Living (ADLs- routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves) per facility protocol and policy. These failures resulted in delayed services to maintain good grooming and personal hygiene for Residents 1 and 2. Findings: During a review of Resident 1 ' s Admission Record, the Admission Record indicated Resident 1 was admitted to the facility on [DATE] with diagnoses that included benign prostatic hyperplasia (BPH - age-associated prostate gland enlargement that can cause urination difficulty), hemiplegia (paralysis of one side of the body) and hemiparesis (inability to move one side of the body). During a review of Resident 1 ' s Minimum Data Set (MDS- resident assessment tool), dated 10/29/2024, the MDS indicated Resident 1 with severely impaired cognitive skills (ability to understand and make decisions). The MDS also indicated Resident 1 was dependent (helper does all effort needed to complete activity) with oral, personal and toileting hygiene, bathing and dressing. The MDS also indicated Resident 1 is always incontinent (lacking control) of urine and bowel. During a review of Resident 1 ' s History & Physical (H&P) dated 10/22/2024, the H&P indicated Resident 1 could make needs known but could not make medical decisions. During a review of Resident 1 ' s Activities of Daily Life Self-Care Performance Deficit care plan (a document that outlines the facility ' s plan to provide personalized care to a resident that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs), dated 10/29/2024, the care plan indicated the resident was totally dependent on staff for bathing, showering, dressing, bed mobility, personal hygiene and oral care. During a concurrent observation and interview on 1/23/2025 at 2:58PM with Certified Nurse Assistant 1 (CNA 1) at Resident 2 ' s bedside, CNA 1 was observed opening the incontinence brief (diaper) of Resident 2 which had yellow urine observed in the diaper. CNA 1 stated Resident 2 urinated, but only a little bit, and would clean the resident when it is time for resident 2 ' s repositioning. (continued on next page)

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

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 2 ' s Admission Record, the Admission Record indicated Resident 2 was admitted to the facility on [DATE] with diagnoses that included cerebral ischemia (blood flow to the brain is reduced or blocked, leading to a lack of oxygen and nutrients) , encephalopathy (impairment of brain function), dysphasia (difficulty swallowing) and cognitive communication deficit (difficulty with communication caused by an impairment in cognitive processes). During a review of Resident 2 ' s MDS dated [DATE], the MDS indicated Resident 2 had severe impaired cognitive skills. The MDS also indicated Resident 1 was dependent (helper does all effort needed to complete activity) with oral and personal hygiene and dressing while toileting hygiene and bathing was not attempted due to a medical condition or safety concern. The MDS also indicated Resident 2 was always incontinent (lacking control) of urine and bowel. During a review of Resident 2 ' s H&P dated 8/4/2024, the H&P indicated Resident 2 could make needs known but could not make medical decisions. During a review of Resident 2 ' s Total Care on ADL care plan, dated 8/4/2024, the care plan indicated the resident was totally dependent on staff for bathing, showering, dressing, bed mobility, personal hygiene and oral care. During an observation on 1/23/2025 at 3:27PM, at Resident 2 ' s bedside CNA 1 and CNA 2 were observed cleaning and changing Resident 2 ' s diaper. During a concurrent observation and interview on 1/24/2025 at 8:10AM with CNA 1 at Resident 1 ' s bedside, Resident 1 was observed with a wet towel, placed over Resident 1 ' s pelvic area, (lower part of the trunk, situated between the thighs and abdomen) that was soiled with urine. There was a chuck (an absorbent pad used to protect surfaces from moisture and stains), observed underneath Resident 1, which was also soiled with urine. CNA 1 stated this was the first time Resident 1 was being cleaned during the day shift, which started at 7am because she arrived to work late. CNA 1 could not state the last time Resident 1 was cleaned or changed. During an interview on 1/24/2025 at 9:32AM with CNA 2, CNA 2 stated the facility protocol was to round residents every two hours and as needed for cleaning and repositioning, and to clean residents at the same time they see the residents have urinated or had a bowel movement. During a review of the facility ' s Policy & Procedure (P&P) titled Activities of Daily Living (ADLs), Supporting, revised 3/2018, the P&P indicated residents who are unable to carry out ADLs independently will receive the services necessary to maintain good nutrition, grooming and personal and oral hygiene. The P&P also indicated appropriate care and services will be provided for residents unable to carry out ADLs independently including appropriate support and assistance with hygiene (bathing, dressing, grooming and oral care) and elimination (toileting).

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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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48152 Based on observation, interview and record review, the facility failed to maintain appropriate respiratory care for one of three sampled residents (Resident 1), by failing to: 1. Administer 2 liters of continuous (without interruption) oxygen therapy (a treatment that provides extra oxygen to people who have breathing problems or low oxygen levels in their blood) as ordered. 2. Maintain infection control when oxygen tubing (a flexible, clear hose that carries oxygen from a source to a delivery device), became contaminated (the presence of an infectious agents- bacteria, viruses, microbes) and was not discarded per facility protocol. These failures resulted in Resident 1 not receiving the accurately prescribed amount of oxygen and had the potential to result in respiratory complication and/or infection. Findings: During a review of Resident 1 ' s Admission Record, the Admission Record indicated Resident 1 was admitted to the facility on [DATE] with diagnoses that included chronic respiratory failure (a long term condition that occurs when the lungs cannot get enough oxygen into the blood or eliminate enough carbon dioxide from the body), encounter for attention to tracheostomy (an artificial opening through the neck usually for the relief of difficulty in breathing), hemiplegia (paralysis of one side of the body) and hemiparesis (inability to move one side of the body). During a review of Resident 1 ' s Minimum Data Set (MDS- resident assessment tool), dated 10/29/2024, the MDS indicated Resident 1 with severely impaired cognitive skills (ability to understand and make decisions). The MDS also indicated Resident 1 was dependent (helper does all effort needed to complete activity) with oral, personal and toileting hygiene, bathing and dressing. The MDS also indicated Resident 1 receiving oxygen therapy while a resident at the facility. During a review of Resident 1 ' s History & Physical (H&P) dated 10/22/2024, the H&P indicated Resident 1 could make needs known but cannot make medical decisions. During a review of Resident 1 ' s Order Summary Report, dated 1/24/2025, the Order Summary Report indicated an order for continuous T-Bar (a T-shaped piece of tubing used to deliver oxygen to patients) at 28% FiO2 (fraction of inspired oxygen- the percentage or concentration of oxygen that a person inhales) at 2 liters per minute (LPM) every 12 hour. During a review of Resident 1 ' s Risk for Shortness of Breath (SOB) Related To Chronic Respiratory Failure care plan (a document that outlines the facility ' s plan to provide personalized care to a resident that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs), dated 10/25/2024, the care plan indicated Resident 1 was on continuous T-Bar at 28% FIO2 at 2 LPM. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a continuous observation on 1/24/2025 from 8:10AM to 8:33AM at Resident 1 ' s bedside with Certified Nurse Assistant 1 (CNA 1), Resident 1 ' s T-bar was observed disconnected from the oxygen tubing and the opened end of oxygen tubing was observed on the floor while still connected to the oxygen concentrator (a medical device that produces a higher concentration of oxygen from the room air). CNA 1 was observed picking up the exposed end the oxygen tubing from the floor and placing it inside of Resident 1 ' s nightstand drawer. During an observation on 1/24/2025 at 8:33AM at Resident 1 ' s bedside with CNA 1 and Licensed Vocational Nurse 1 (LVN 1), LVN 1 observed Resident 1 with no oxygen therapy administration and requested tubing from Resident 1 ' s nightstand drawer. CNA 1 was observed handing LVN 1 the [contaminated] tubing for reconnection. During an interview on 1/24/2025 on 1/24/2025 at 9:16AM with the Respiratory Therapist (RT), RT stated Resident 1 was receiving continuous oxygen therapy due to having a stroke (a serious life-threatening medical condition that happens when the blood supply to part of the brain is cut off). During an interview on 1/24/2025 at 10:56AM with LVN 1, LVN 1 stated CNA 1 did not inform LVN 1 that Resident 1 ' s oxygen tubing had become disconnected or contaminated by being on the floor and per facility protocol, CNA 1 should have made him aware immediately so that the tubing could be replaced and reconnected to ensure Resident 1 received the prescribed necessary oxygen. LVN 1 stated Resident 1 was on continuous oxygen therapy due to respiratory failure and required continuous oxygen to keep breathing. LVN 1 also stated Resident 1 was immunocompromised (a weakened immune system) and could be at risk for an infection and worsening health condition if a contaminated oxygen tubing was used. During an interview on 1/24/2025 at 11:38AM with the Infection Preventionist Nurse (IPN), IPN stated per the facility protocol, when an oxygen tubing falls on the floor, the tubing must be changed and not given to the resident for use because it was already considered contaminated. The IPN stated the contaminated tubing placed the resident at risk for infection. During an interview on 1/24/2025 at 11:48AM with the Director of Nursing (DON), the DON stated per the facility protocol, CAN ' s s was to report to the LVN ' s immediately when oxygen tubing disconnects from the resident and/or falls on the floor so that oxygen tubing could be reconnected and replaced to ensure the resident ' s safety and maintain infection control. The DON also stated residents could experience respiratory distress, hospital transfers, respiratory infections and sepsis (a life-threatening blood infection) if continuous oxygen therapy and infection control are not maintained. During a concurrent interview and record review on 1/24/2025 at 11:57AM with IPN, the facility ' s P&P titled Cleaning and Disinfection of Resident-Care Items and Equipment revised 10/2018, was reviewed. The P&P indicated resident-care equipment including respiratory therapy equipment should be free from all microorganisms. IPN stated oxygen cannulas become contaminated [with microorganisms] when on the floor, visibly soiled and/or when placed on top of any surface without being in a respiratory bag. IPN also stated the oxygen cannula used for Resident 1 is disposable and staff are to dispose and replace the cannula to maintain prevention of microorganism development on the oxygen cannula. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility ' s Policy and Procedure (P&P) titled, Oxygen Administration revised 10/2010, the P&P indicated the purpose is to provide guidelines for safe oxygen administration, staff are to verify that there is a physician's order for this procedure, review the physician's orders or facility protocol for oxygen administration, adjust oxygen delivery so that it is the proper flow being administered and periodically observe the resident after set up to ensure oxygen is being tolerated.

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F 0790 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide routine and 24-hour emergency dental care for each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48152 Based on observation, interview and record review, the facility failed to follow up and ensure dental services were provided for one of three residents (Resident 1), as indicated in the physician ' s order and facility policy. This failure resulted in Resident 1 receiving delayed dental services with the potential risk for a decline in his oral health. Findings: During a review of Resident 1 ' s Admission Record, the Admission Record indicated Resident 1 was admitted to the facility on [DATE] with diagnoses that included gastro-esophageal reflux disease (GERD - chronic digestive disease where the contents of the stomach refluxes and irritates the esophagus), encounter attention for gastrostomy (a surgical opening fitted with a device to allow feedings to be administered directly to the stomach common for people with swallowing problems), hemiplegia (paralysis of one side of the body) and hemiparesis (inability to move one side of the body). During a review of Resident 1 ' s Minimum Data Set (MDS- a resident assessment tool), dated 10/29/2024, the MDS indicated Resident 1 had severely impaired cognitive skills (ability to understand and make decisions). The MDS also indicated Resident 1 was dependent (helper does all effort needed to complete activity) with oral, personal and toileting hygiene, bathing and dressing. The MDS also indicated Resident 1 receiving oxygen therapy while a resident at the facility. During a review of Resident 1 ' s History & Physical (H&P) dated 10/22/2024, the H&P indicated Resident 1 could make needs known but could not make medical decisions. During a review of Resident 1 ' s Order Summary Report dated 10/22/2024, the Order Summary Report indicated dental consult and treatment as needed. During a review of Resident 1 ' s Activities of Daily Life (ADL- routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves) Self-Care Performance Deficit care plan (a document that outlines the facility ' s plan to provide personalized care to a resident that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs), dated 10/29/2024, the care plan indicated the resident was personally dependent on staff for personal hygiene and oral care. During a record review of Resident 1 ' s Dental Note, dated 10/24/2024, the note indicated a dental exam was done by Doctor of Dental Medicine 1 (DDM 1) and Resident 1 needed a deep cleaning by facility ' s in-house hygienist. (continued on next page)

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F 0790 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent observation and interview on 1/24/2025 at 2:04PM with Licensed Vocational Nurse 1 (LVN 1), at Resident 1 ' s bedside, resident 1 ' s oral condition was observed. LVN 1 stated Resident 1 had missing teeth, some teeth had plaque (a soft sticky film of bacteria that constantly forms on your teeth and hardens when not removed) and white stuff on the tongue. LVN 1 stated he was not aware until 1/24/2025 that Resident 1 had a referral for a deep cleaning of his teeth. LVN 1 stated when referrals are note after consultations, Social Services Director (SSD) should communicate recommendations, pending referrals and all required follow ups to the licensed staff. LVN 1 stated he was unaware that Resident 1 had a referral to see a dental hygienist for deep cleaning, and could not state if a deep cleaning was conducted on Resident 1 ' s teeth. During a concurrent interview on 1/24/2025 at 2:29PM with the Social Services Director (SSD), SSD ' s dental hygienist referral email, dated 11/18/2024 was reviewed. The email indicated the request for a dental hygienist consult for Resident 1. SSD stated 11/18/2024 was the first follow up the SSD conducted after Resident 1 ' s dental exam on 10/24/2024 and could not remember what caused the delay from 10/24/2024 to 11/18/2024. SSD stated once Family Member 1 requested a dental exam, SSD went through Resident 1 ' s chart to discover an exam had been completed with the note for hygienist referral. SSD stated he should have sent the referral for the hygienist once the exam was completed because it was a service that was supposed to be provided to Resident 1 and the facility policy to follow up and assist with all referrals. During a review of the facility ' s Policy & Procedure (P&P) titled Dental Services, revised 12/2026, the P&P indicated routine, and emergency dental services are available to meet the resident ' s oral health services in accordance with the resident ' s assessment and plan of care and that social services representatives will assist residents with appointments. During a review of the facility ' s P&P titled Ancillary Services, (undated), the P&P indicated it is the facility ' s policy to refer each resident to any ancillary services including dental and that the SSD will coordinate with nursing department the resident ' s needs for ancillary services, the SSD will document the arrangement made on his/her social service notes with other pertinent information and the SSD will coordinate with nursing department for any future visit(s), noting frequency may vary according to the resident ' s needs.

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F 0825 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or get specialized rehabilitative services as required for a resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48152 Based on observation, interview and record review, the facility failed to ensure there would not be a delay in physical therapy (PT- treatment that helps improve how the body performs physical movements) and occupational therapy (OT- treatment that helps improve a person ' s ability to perform daily tasks) services provided for one of three sampled residents (Resident 1), after ordered by the physician. This failure resulted in delayed PT and OT therapy treatment and services for Resident 1, and placed Resident 1 at higher risk for further range of motion (ROM-the full movement potential of a joint, usually its range of flexion and extension) decline. Findings: During a review of Resident 1 ' s Admission Record, the Admission Record indicated Resident 1 was admitted to the facility on [DATE] with diagnoses that included hemiplegia (paralysis of one side of the body) and hemiparesis (inability to move one side of the body) following cerebral infarction (also known as a stroke; refers to damage to the tissues in the brain due to a loss of oxygen to the area) affecting left non-dominant side. During a review of Resident 1 ' s Minimum Data Set (MDS- resident assessment tool), dated 10/29/2024, the MDS indicated Resident 1 with severely impaired cognitive skills (ability to understand and make decisions). The MDS also indicated Resident 1 was dependent (helper does all effort needed to complete activity) with oral, personal and toileting hygiene, bathing and dressing. The MDS also indicated Resident 1 had an impairment on both sides of the upper extremities (shoulders, elbows, wrists, hands), lower extremities (hips, knees, ankles, feet). During a review of Resident 1 ' s History & Physical (H&P) dated 10/22/2024, the H&P indicated Resident 1 could make needs known but could not make medical decisions. During a review of Resident 1 ' s Physician ' s Order, dated 10/24/2024, the order indicated for PT and OT evaluation and treatment. During a review of Resident 1 ' s faxed Notice of Authorization of Services report dated 11/13/2024, the notice indicated Resident 1 was approved to receive OT and PT services beginning 11/12/2024 to 2/12/2025, and the fax was received from the facility on 11/13/2024. During a review of Resident 1 ' s PT Evaluation & Plan of Treatment (undated), the evaluation and treatment plan indicated 12/2/2024 as the PT services start of care date with a certification period from 12/2/2024 - 12/29/2024. The PT evaluation and treatment plan also indicated Resident 1 required skilled PT services to facilitate with all functional mobility to enhance Resident 1 ' s quality of life. (continued on next page)

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F 0825 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 1 ' s OT Evaluation & Plan of Treatment (undated), the evaluation and treatment plan indicated 12/3/2024 as the start of care [OT services] with a certification period from 12/3/2024 - 12/30/2024. The OT evaluation and treatment plan also indicated Resident 1 required OT services to assess safety and independence with self-care and functional tasks of choice and increase functional activity tolerance. During a review of Resident 1 ' s Joint Mobility Assessments dated 10/23/2024 and 12/3/2024, the assessments indicated during the period of 10/23/2024 to 12/3/2024, Resident 1 had the following joint mobility changes: Right shoulder mobility from minimal to moderate. Right hand/fingers mobility from minimal to moderate. Left and right hip mobility from WFL (within functional limits) to minimal. Left and right knee from WFL to minimal. The assessments also indicated WFL: a limitation up to 25%, minimal: a limitation of 25-50%, moderate: a limitation of 50-75% and severe: a limitation of 70-100%. During a review of Resident 1 ' s medical chart, the chart did not indicate any documentation that PT/OT services were conducted on Resident 1 between 11/13/2024 to 12/2/2024. During an interview on 1/24/2025 at 2:44PM with the Director of Rehab (DOR), the DOR stated Resident 1 did not receive rehab services upon approval on 11/13/24, because the rehab department did not know how many sessions Resident 1 required and was authorized to have. During an interview 1/24/2025 at 4:14PM with the Administrator, the Administrator stated it was the facility ' s process that once therapy services have been authorized and cleared, rehab services would complete their evaluations and rehab services would be initiated either the same day or the next day. During an interview on 1/24/2025 at 4:20PM with the Director of Nursing (DON), the DON stated Resident 1 should have started receiving PT and OT services once the authorization was approved on 11/13/2024. During a review of the facility ' s Policy & Procedure (P&P) titled, Specialized Rehabilitative Services revised 12/2009, the P&P indicated therapeutic services are provided upon the written order of the resident ' s attending physician. During a review of the facility ' s P&P titled, Resident Mobility and Range of Motion, revised 7/2017, the P&P indicated Residents with limited range of motion will receive treatment and services to increase and/or prevent a further decrease in ROM. The P&P also indicated Residents with limited mobility will receive appropriate services, equipment and assistance to maintain or improve mobility unless reduction in mobility is unavoidable.