

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 056316	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/26/2025
NAME OF PROVIDER OR SUPPLIER Camellia Gardens Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44636</p> <p>Based on interview and record review the facility failed to activities of daily living care assistance were provided for one of two sampled residents (Resident 1) by failing to ensure:</p> <p>a. Resident 1 was assessed for incontinence (involuntary loss of urine or stool) care in accordance with the plan of care.</p> <p>b. Resident 1 received tongue scraping (the practice of using a tool such as metal tongue scraper to gently remove bacteria, food particles, and other debris from the surface of the tongue, promoting better oral hygiene and potentially reducing bad breath) in accordance with the physician order.</p> <p>These deficient practices had the potential to lead to skin breakdown, poor hygiene, and diminished quality of life.</p> <p>Findings:</p> <p>During a review of Resident 1's Admission Record, the Admission Record indicated Resident 1 was admitted to the facility on [DATE], with diagnoses of hemiplegia (a condition caused by brain damage or spinal cord injury that leads to paralysis [loss of motor function in one or more muscles] on one side of the body) and hemiparesis (weakness on one side of the body) following cerebral infarction (a stroke, damage to tissue in the brain due to loss of oxygen to the area) affecting left non-dominant side, benign prostatic hyperplasia (age-associated prostate gland enlargement that can cause urination difficulty), and encounter for attention to tracheostomy (a surgically created hole in the windpipe that provides an alternative airway for breathing).</p> <p>During a record review of Resident 1's care plan, revised 1/27/2025, the care plan indicated Resident 1 had an ADL self-care performance deficit related to late effects cerebrovascular accident (CVA - stroke; damage to the brain from interruption of its blood supply) and hemiplegia. The care plan interventions were to provide personal hygiene/oral care since Resident 1 was totally dependent (helper does all the effort and resident does none of the effort to complete the activity) on staff for personal hygiene and oral care.</p> <p>(continued on next page)</p>		

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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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a record review of Resident 1's Minimum Data Set (MDS, a resident assessment and tool), dated 1/29/2025, the MDS indicated the resident's cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decision making was severely impaired. The MDS indicated Resident 1 had impairment to both sides of the upper extremities (shoulders, elbows, wrists, and hands) and lower extremities (hips, knees, ankles, feet). The MDS indicated Resident 1 was dependent for oral hygiene, toileting hygiene, shower/bathing self, personal hygiene, rolling left and right, lying to sitting on side of bed, and tub/shower transferring.</p> <p>During a record review of Resident 1's Nursing Note, dated 3/9/2025 at 8:15 PM, the record indicated found Resident 1 soaking wet. The record indicated per Certified Nursing Assistant 1 (CNA 1), CNA 1 stated Resident 1 was last checked around 4 PM to 4:30 PM.</p> <p>During a record review of Resident 1's Physician Order Summary Report, dated 3/12/2025, the order indicated metal tongue scraper once a day best to do after dinner, scrape the tongue gently with metal tongue scraper.</p> <p>During a record review of Resident 1's Medication Administration Record (MAR, a medical record used by healthcare providers to document the administration of a medication or treatment) for the month of March 2025, the record did not indicate the order for tongue scraping was transcribed in the MAR and it was done for Resident 1.</p> <p>During a record review of Resident 1's care plan, revised 3/25/2025, the care plan indicated Resident 1 had bowel and bladder incontinence related to impaired mobility and cognitive deficit. The care plan interventions for staff were to check every two (2) hours and as required for incontinence; wash, rinse, and dry perineum; and change clothing as needed after incontinence episodes.</p> <p>a. During an interview on 3/25/2025 at 8:59 AM with Responsible Party 1 (RP 1), RP 1 stated on 3/9/2025 RP 1 arrived in Resident 1's room and found Resident 1's gown was completely soaked in urine. RP 1 stated Resident 1's brief (protective underwear to prevent leakage) was huge, and the mattress sheets and the side pillows were also soaked in urine.</p> <p>During an interview on 3/26/2025 at 1:54 PM with Registered Nurse Supervisor 1 (RNS 1), RNS 1 stated RP 1 called RNS 1 into Resident 1's room on 3/9/2025 around 8 PM. RNS 1 stated Resident 1 was really soaked with urine. RNS 1 stated Resident 1's brief was filled with urine and there was urine on the bedsheet and gown. RNS 1 stated CNA 1 told RNS 1 on 3/9/2025 that CNA 1 last checked on Resident 1 around 4 PM to 4:30 PM. RNS 1 stated CNA 1 was supposed to check Resident 1 every 2 hours. RNS 1 stated Resident 1 was prone to an infection since the resident was taking antibiotics (a medication used to kill bacteria and to treat infections) for a urinary tract infection (UTI, an infection of the bladder and urinary system).</p> <p>During an interview on 3/26/2025 at 3:25 PM with the Director of Nursing (DON), the DON stated staff should be reassessing residents every 2 hours. During a concurrent record review of Resident 1's Nursing Notes dated 3/9/2025 at 8:15 PM, the record indicated found Resident 1 soaking wet and CNA 1 last checked the resident between 4 PM to 4:30 PM. The DON stated Resident 1 had not been assessed for three (3) hours and 45 minutes. During a concurrent record review of Resident 1's Care Plan revised 3/25/2025, the care plan indicated for the staff to check Resident 1 every two hours or as needed for incontinence. The DON stated, staff did not and were supposed to check Resident 1 every 2 hours and as required for incontinence care.</p> <p>(continued on next page)</p>

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>b. During a concurrent interview and record review with Licensed Vocational Nurse 1 (LVN 1) on 3/25/2025 at 2:54 PM, Resident 1's MAR for the month of March 2025 was reviewed. The MAR did not indicated tongue scraping was provided for Resident 1. LVN 1 stated there was an order for Resident 1's tongue scraping to be done in the evening. LVN 1 stated the license nurses needed to document in the MAR to indicate the tongue scraping was done. LVN 1 stated the tongue scrapping should have been logged if it was done and it was not in the MAR.</p> <p>During a concurrent interview and record review with RNS 2 on 3/25/2025 at 3:17 PM, Resident 1's MAR for the month of March 2025 was reviewed. The MAR did not indicate the order for tongue scraping was transcribed in the MAR and it was done for Resident 1. RNS 2 stated Resident 1 required total care with ADLs. RNS 2 stated the physician placed an order for Resident 1's tongue scraping on 3/12/2025 and it was not transcribed/ reflected in Resident 1's MAR. RNS 2 stated the licensed nurses needed to document in the MAR once the procedure was done. RNS 2 stated the documentation in the MAR was to confirm that the order was done. RNS 2 stated if the tongue scraping was not documented, then the licensed nurse did not complete the order and did not provide the tongue scraping to Resident 1. A concurrent record review of Resident 1's Nursing Notes with RNS 2, RNS 2 stated the Nursing Notes did not indicate the tongue scraping was done.</p> <p>During an interview on 3/26/2025 at 3:32 PM with the DON, the DON stated the physician's order needed to be acknowledged, transcribed in the MAR, and signed in the MAR once treatment is done. The DON stated the licensed nurses did not and should have documented in Resident 1's medical records the tongue scraping once the procedure was done. The DON stated documentation was needed for the justification that the license nurses performed the tongue scraping per physician's order.</p> <p>During a record review of the facility's policy and procedure titled, Activities of Daily Living (ADLs), Supporting, revised 3/2018, the policy indicated appropriate care and services will be provided for residents who are unable to carry out ADLs independently, with the consent of the resident and in accordance with the plan of care, including appropriate support and assistance with hygiene (bathing, dressing, grooming, and oral care) and elimination (toileting).</p>		