

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 04/11/2025
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 0694</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide for the safe, appropriate administration of IV fluids for a resident when needed.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45456</p> <p>Based on observation, interview and record review, the facility failed to monitor the intravenous (IV, a small flexible tube placed into a small vein for intravenous therapy such as medication fluids) site and change the heplock (a type of IV device for the administration of solution or medication) dressing for two (2) of 3 sampled residents (Resident 1 and Resident 2) in accordance with the facility policy.</p> <p>This deficient practice had the potential to result in Resident 1 and Resident 2 to develop IV complications which can lead to infection and possible hospitalization .</p> <p>Findings:</p> <p>1. During a review of Resident 1's Admission Record, the Admission Record indicated Resident 1 was originally admitted to the facility on [DATE]. Resident 1's diagnoses included vancomycin-resistant enterococci (VRE, a type of bacteria that is resistant to vancomycin [a common antibiotic]) of permacath (a long-term catheter used for dialysis [a treatment to cleanse the blood of wastes and extra fluids artificially through a machine when the kidney(s) have failed] treatment), and diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing).</p> <p>During a review of Resident 1's Minimum Data Set (MDS, resident assessment tool), dated 4/16/2025, the MDS indicated Resident 1 was moderately impaired with cognitive skills (ability to think, understand, and reason) for daily decision making. The MDS indicated Resident 1 was dependent (helper does all of the effort, resident does none of the effort to complete the activity) with oral hygiene, toileting hygiene, shower/ bathe self, upper and lower body dressing, putting on/ taking off footwear, personal hygiene, roll left and right, sit to lying, lying to sitting on side of bed, sit to stand and chair/bed-to -chair transfer.</p> <p>During a review of Resident 1's Physician's Order Summary, with an order date of 4/9/2025, the Physician's Order Summary indicated Daptomycin (used to treat certain blood infections) Intravenous Solution 500 milligram (mg, unit of measurement) every 48 hours for VRE of the permacath until 4/13/2025.</p> <p>During an observation on 4/11/2025 at 9:30 AM in Resident 1's room, Resident 1 was awake and laying on his bed. Resident 1 was observed with a peripheral IV site on her right hand. The IV site had a grayish colored and blood-stained bandage dressing. There was a dried blood on the paper tape on her hand that was placed next to the IV access port.</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 0694</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a concurrent observation and interview on 4/11/2025 at 9:35 AM with Registered Nurse 2 (RN 2) in Resident 1's room, Resident 1's IV site was observed with blood stains. RN 2 stated, Resident 1's IV site was not clean and well secured. RN 2 stated, We should always secure the IV site to prevent dislodgment and always keep it clean to prevent infection.</p> <p>During an interview on 4/11/2025 at 9: 55 AM with Infection Preventionist Nurse (IPN), IPN stated, Resident (Resident 1)'s IV site was visibly soiled because there is blood on the tape that was attached on the gauze. The licensed staff should have changed the IV dressing because the area was visibly soiled. We need to always keep the IV site clean because of infection control.</p> <p>During a concurrent interview and record review on 4/11/2025 at 11:58 AM with IPN, Resident 1's Physician's order dated 4/9/2025 was reviewed. The physician's order indicated Daptomycin every 2 days (48 hours) via intravenous. IPN stated Resident 1 did not and should have a physician's order to monitoring the IV site to include changing the dressing every seven days or as needed when compromised.</p> <p>During a concurrent interview and record review on 4/11/2025 at 12PM with IPN, Resident 1's Medication Administration Record dated 4/1/2025 to 4/30/2025 was reviewed. IPN stated Resident 1 had no IV site monitoring from 4/9/2025 to 4/10/2025. IV monitoring was not initiated until today (4/11/2025).</p> <p>During a concurrent interview and record review on 4/11/2025 at 12:02 PM with IPN, Resident 1's Care Plan IV dated 4/11/2025 was reviewed. IPN stated the Care Plan indicated PICC line. IPN stated, Care plan had incorrect information because Resident 1 did not have a PICC line and only had peripheral IV line. IPN also stated the care plan intervention was incomplete because there was no monitoring indicated.</p> <p>During an interview on 4/11/2025 at 12:06 PM with IPN, IPN stated If there was no monitoring of IV site for Resident 1, the licensed nurses will not be able to assess if there were signs and symptoms of infiltration, or any complications on the IV site.</p> <p>During a concurrent interview and record review on 4/23/2025 at 12:08 PM, Resident 1's Nurses' Progress notes dated 4/9/2025 to 4/10/2025 were reviewed. There was no record of assessment on the IV site for Resident 1 during 7AM to 3PM shift on 4/10/2025. IPN stated there was no IV site assessment done for Resident1 in the morning shift. IPN stated the Charge nurse missed assessing and documenting Resident 1's IV site. IPN stated, if the nursing staff did not conduct an IV site assessment, there is a possibility of delayed treatment if complication such as infection and infiltration occurs.</p> <p>During a concurrent observation and interview on 4/11/2025 at 12:15PM with MDSN Nurse (MDSN), MDSN stated Resident 1's peripheral IV site looks dirty because there was dry blood on the site. MDSN stated, The nursing staff should have changed the IV dressing right away because it was compromised.</p> <p>During a concurrent interview and record review on 4/11/2025 at 12:17 PM with MDSN, Resident 1's Care Plan IV dated 4/11/2025 was reviewed. MDSN stated Care Plan indicated Resident 1 had a PICC line. MDSN stated it should have indicated an IV access of a peripheral line and not a PICC line. MDSN also stated the care plan should have included interventions to monitoring signs of infection of the peripheral IV site.</p> <p>(continued on next page)</p>		

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<p>F 0694</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a concurrent interview and record review on 4/23/2025 at 12:20PM with MDSN, Resident 2's progress notes were reviewed. MDSN stated there was no documentation that Resident 1's IV site was assessed and if IV site care was done such as flushing the site or dressing change. MDSN stated these should have been documented on the progress notes to indicate IV site assessment and care have been done for Resident 1.</p> <p>During a concurrent interview and record review on 4/11/2025 at 12:21 PM with IPN, Resident 1's Medication Administration Record (MAR) dated 4/1/2025 to 4/30/2025 was reviewed. IPN stated MAR did not indicate IV monitoring from 4/9/2025 to 4/10/2025. MDSN stated there was no IV monitoring in Resident 1's MAR until 4/11/2025. IPN stated the licensed staff should have documented it in the progress notes if it is not in the MAR. IPN stated the staff has to make sure they check the IV site daily.</p> <p>During an interview on 4/11/2025 at 12:23 PM with MDSN, MDSN stated, the licensed staff should have documented any signs and symptoms of infection of Resident 1's IV site and adverse effect of medications, if there was any. MDSN stated if licensed staff did not monitor, the IV site can get infected, possible bleeding or infiltrate.</p> <p>2. During a review of Resident 2's Admission Record, the Admission Record indicated Resident 1 was originally admitted to the facility on [DATE]. Resident 1's diagnoses included sepsis (a life-threatening blood infection), pneumonia (an infection/inflammation in the lungs), and chronic obstructive pulmonary disease (COPD, a chronic lung disease causing difficulty in breathing).</p> <p>During a review of Resident 2's MDS, dated [DATE], the MDS indicated Resident 1 was moderately impaired with cognitive skills for daily decision making. The MDS indicated Resident 1 needs substantial/ maximal assistance (helper does more than half the effort. helper lifts, holds trunk or limbs, and provides more than half the effort) in toileting hygiene, shower/ bathe self, lower body dressing, putting on/ taking off footwear, sit to lying, lying to sitting on side of bed, sit to stand chair/bed-to -chair transfer, and tub/shower transfer.</p> <p>During a review of Resident 2's physician's order dated 3/16/2025, the physician's order did not indicate IV site monitoring and discontinue the IV site if not in use for Resident 2.</p> <p>During a review of Resident 2's nurses' progress notes dated 3/16/2025 to 3/22/2025. The nurses' progress notes did not indicate any IV site monitoring for Resident 2.</p> <p>During an interview on 4/11/2025 at 3:08 PM with RN 2, RN 2 stated, We do not give medications via IV push. We usually call the physician and have the order changed to oral, but we also need to get an order to discontinue the IV site and remove the IV. If a resident has an IV site, we need to monitor the IV site to make sure the site has no signs of infection, bleeding or inflammation.</p> <p>During an interview on 4/11/2025 at 3:10PM with IPN, IPN stated, If a resident was admitted with IV medications, it will be changed to oral route, and we should also get an order to discontinue the IV line. But if the resident has IV access and staff were not using it, we need to monitor the IV site to prevent IV site complications.</p> <p>(continued on next page)</p>		

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<p>F 0694</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 4/11/2025 at 3:14 PM with the Director of Nursing, the DON stated, The licensed staff should have a physician's order to monitor the IV site. If IV medications were changed to oral, we have to make sure to obtain an order to discontinue the Resident's IV access if resident was not using it for a specific number of days.</p> <p>During an interview on 4/11/2025 at 3:16 PM with RN 1, RN 1 stated Resident 2 had two peripheral IV lines on the bilateral hands upon admission. RN 1 stated, We removed the IV line on the right hand but Resident 2 was left with the peripheral IV on his left hand. The physician changed the prednisone IV medication order to oral route. We did not discontinue the IV site because we might still need to use it. I forgot to ask the physician for IV site monitoring order. We were not able to monitor Resident 2's IV site.</p> <p>During an interview on 4/11/2025 at 3:18 PM with RN 1, RN 1 stated, If Resident (Resident 2)'s IV site was not monitored, there is a possibility that the Resident can have an infection on the IV site.</p> <p>During an interview on 4/23/2025 at 3:59 PM with the DON, the DON stated, If there was no monitoring and care plan for Resident (Resident 2)'s IV site, it means the licensed staff did not properly assess the resident. The Licensed staff were not able to document and implement proper interventions and address any issues and inform the physician.</p> <p>During a concurrent interview and record review on 4/11/2025 at 4:03 PM with the DON, Resident 2's Nurse's progress notes dated 3/16/2025 to 3/22/2025 were reviewed. The DON stated, The licensed staff did not document any assessment regarding Resident 2's IV site in their progress notes, it means the licensed staff were not checking Resident 2's IV site for signs and symptoms of IV complications from 3/16/2025 to 3/22/2025.</p> <p>During an interview on 4/11/2025 at 4:06 PM with the DON, the DON stated, If a resident has an IV access and the licensed staff were not monitoring it, it can be a source of infection to the resident, because it can develop cellulitis and phlebitis.</p> <p>During a review of the facility's policy and procedure (P&P) titled, Peripheral and Midline IV Dressing Change, revised 3/2022, the P&P indicated Change the dressing if it becomes damp, loosened or visibly soiled and:</p> <ul style="list-style-type: none"> c. immediately if the dressing or site appears compromised. 6. Assess the peripheral/midline access device at least every 4 hours (every 1-2 hours for residents with cognitive impairment). <ul style="list-style-type: none"> a. Visually inspect the entire infusion system (solution, administration set and dressing). b. Check expiration dates of the infusion, dressing and administration set. c. Assess the patency of the vascular access device. d. Palpate and inspect the skin, dressing and securement device for signs of complications, including: <p>(continued on next page)</p>		

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