

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 05/13/2025
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 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate pressure ulcer care and prevent new ulcers from developing.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48143</p> <p>The facility failed to provide care consistent with the professional standards of practice (the set of guidelines, principles, and expectations that govern the conduct and performance of nursing professionals) to prevent worsening of the pressure ulcer (PU, a localized area of skin damage caused by prolonged pressure on the skin) for one of two sampled residents (Resident 1) by failing to:</p> <ol style="list-style-type: none"> 1. Assess and document detailed observations in SBAR (situation, background, assessment, recommendation-a communication tool used by healthcare workers when there is a change of condition among the residents) of Resident 1's change with skin condition and/ or wound condition on the resident's left trochanter area (a small, conical projection located on the medial side of the upper femur, specifically at the junction of the femoral neck and shaft) on 4/10/2025, 4/17/2025 and 4/24/2025. 2. Resident 1's change of skin condition and/ or wound condition on the resident's sacral area (lower back region specifically triangular- shaped bone called the sacrum) on 4/24/2025. <p>These failures placed Resident 1 at risk for worsening of the PU that can lead to serious illness and/ or hospitalization .</p> <p>Findings:</p> <p>A review of Resident 1's Admission Record, the Admission Record indicated Resident is a 84- years- old- female who was admitted to the facility on [DATE] with diagnoses that included encephalopathy (damage or disease that affects the brain, essential hypertension (high blood pressure that doesn't have a known underlying cause), and other pulmonary embolism without acute core pulmonale (pulmonary embolism, blood clot, that is not severe enough to immediately cause damage to the right side of the heart).</p> <p>During a review of Resident 1's History and Physical (H&P), dated 2/16/2025, the H&P indicated Resident 1 has no capacity to understand and make decisions.</p> <p>During a review of Resident 1's MDS (a resident assessment tool) dated 2/11/2025, indicated Resident 1 was independent, (helper does more than half the effort) with roll on the left and right, sit to lying, and personal hygiene. The MDS also indicated Resident 1 was assessed to be dependent (helper does all of the effort to complete the activity) on sit to stand, chair/bed-to-chair transfer and toilet hygiene. The MDS indicated Resident 1 was assessed to be at risk of developing pressure ulcer and the resident has one or more unhealed pressure ulcers/injuries (location not specified).</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 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a review of the GACH records with an admitted [DATE] and discharge date of [DATE], the GACH records indicated Resident 1 was admitted with altered mental status (a change in a person's mental functioning, ranging from mild confusion to severe disorientation, and can be caused by various factors like illness, injury, or substance use) , numerous pressure ulcers, hypotensive, and concerns for septic shock (a life-threatening condition that occurs when the body's immune system overreacts to an infection, leading to widespread inflammation and organ damage.)</p> <p>The GACH records indicated discharge diagnoses which included the following:</p> <p>a) Volume depletion (decrease in blood volume and can lead to symptoms like low blood pressure and dehydration).</p> <p>b) G-tube (a thin, flexible tube inserted through the abdominal wall directly into the stomach) site cellulitis (a common bacterial infection of the skin and underlying tissues. It occurs when bacteria enter the skin through a cut, scratch, or other break in the skin).</p> <p>c) Pressure injury of skin,</p> <p>During an interview on 5/12/2025 at 12:12 PM with wound treatment nurse (WTN), WTN stated she is new to the wound treatment nurse position, she was working as a wound treatment nurse for just two weeks, she did not know anything about Resident 1's wounds, but WTN stated it is WTN, charge nurse, registered nurse supervisor's (RNS) responsibility to create SBAR communication for significant wound changes to promote immediate attention and actions to the teams for preventing residents wounds getting worse, infections and hospitalization .</p> <p>During an interview on 5/13/2025 at 2:16 PM with Registered Nurse Supervisor (RNS) at nursing station 1, RNS stated certified nursing aid (CNAs) will report residents' skin change to charge nurse, medication passing nurse and supervisors. RNS stated it is licensed nurse's responsibility to start SBAR/COC and report to physician, obtain physician orders and WTN will start wound treatment per physician order.</p> <p>During a concurrent interview and record review with infection preventionist nurse (IPN) on 5/13/2025 at 1:45 PM, Resident 1's Weekly Observation Tool Pressure Injury & IDT Review (WOTPI) dated 2/19/2025 to 4/24/2025 were reviewed, indicated the following:</p> <p>a. On 4/2/2025, Resident 1's stage (classifies the severity of skin and tissue damage) 4 left trochanter [a bony prominence located on the posterior (back) and medial (toward the center) surface of the proximal femur (thigh bone)] wound size</p> <p>L:5.1 cm x W: 5.0cm D: 0.7cm</p> <p>b. On 4/10/2025, Resident 1's stage 4 left trochanter [a bony prominence located on the posterior (back) and medial (toward the center) surface of the proximal femur (thigh bone)] wound size changed to</p> <p>L:6.4 cm x W: 4.5cm x D: 0.7cm</p> <p>c. On 4/17/2025, Resident 1's stage 4 left trochanter wound size changed to</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>L:4.3 cm x W: 5.4cm x D: 0.4cm</p> <p>d. On 4/24/2025, Resident 1's stage 4 left trochanter wound size changed to</p> <p>L:5.3 cm x W: 5.7cm x D: 0.5cm.</p> <p>e. On 4/17/2025, Resident 1's stage 4 sacrococcyx (the junction point where the sacrum and coccyx (tailbone) connect wound size was</p> <p>L: 4.4cm, x W:7.7cm, D, no depth measurement</p> <p>f. On 4/24/2025, Resident 1's stage 4 sacrococcyx wound size changed to</p> <p>L:8.8 cm x W: 8.0cm x D 1.4cm worsening condition.</p> <p>IPN stated there were no SBAR (Situation, Background, Assessment, and Recommendation. It's designed to improve communication between healthcare professionals, particularly when notifying a physician about a patient's change in condition) / change of condition form (COC) documentation had been established for the left trochanter wound size changes noted on 4/10/2025, 4/17/2025, and 4/24/2025. IPN also stated there was no SBAR/COC for sacrococcyx area on 4/24/2025 for Resident 1.</p> <p>IPN stated the above wound size changes of left trochanter 4/10/2025, 4/17/2025, and 4/24/2025, sacrococcyx area wound size change on 4/24/25 are significant changes that need to implement a SBAR communication form for a purpose of communications, the care team's immediate attention and action for care plan revision between physicians and all healthcare professionals to promote wound healings and to prevent further wound infection. Infection Preventionist Nurse stated wound care nurse should have created SBAR communication forms for Resident 1's left trochanter and sacrococcyx wounds to prevent wounds worsening than hospitalized due to wounds infections.</p> <p>During a concurrent interview and record review with director of nurses (DON) on 5/13/2025 at 3:48 PM, Resident 1's Weekly Observation Tool Pressure Injury & IDT Review (WOTPI) dated 4/10/2025, 4/17/2025, and 4/24/2025 for left trochanter wound; and WOTPI dated 4/24/2025 for Resident 1's stage 4 sacrococcyx were significantly changed per Resident 1's WOTPI listed on the above dates for left trochanter and sacrococcyx wounds. DON stated Resident 1's wound size did change from good to bad, these changes were change of conditions. DON stated she would have started the SBAR.</p> <p>DON stated the wound care nurses should have started the SBAR communication form to facilitate the team's immediate attention and action for Resident's wounds to prevent further wounds worsening, infections and hospitalization s.</p> <p>During a concurrent interview and record review on 5/13/2025 at 3:48 PM with DON, the facility's policy and procedure (P&P) titled, Change in a Resident's Condition or Status, undated, revised February 2021 was reviewed. The P&P indicated</p> <p>1. A significant change of condition is a major decline or improvement in the resident's status that:</p> <p>(continued on next page)</p>		

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