

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555729	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/30/2025
NAME OF PROVIDER OR SUPPLIER Arcadia Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1601 S Baldwin Ave. Arcadia, CA 91007	

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 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46687</p> <p>Based on interview and record review, the facility failed to promptly (quickly/with little or no delay) notify one of three sample residents' (Resident 2) Responsible Party (RP 2) when Resident 2 experienced a change in condition (CIC- a sudden clinically important deviation from a resident/patient's baseline in physical, behavioral, or functional domains) as indicated in the facility's policy and procedure (PP) titled, Change of Condition Reporting, by failing to:</p> <p>Ensure RP 2 was notified when Resident 2's Primary Care Provider/Medical Doctor (MD) 1 discontinued Resident 2's Avycaz (brand name for ceftazidime/avibactam- an antibiotic [medicine that stops the growth of or destroys bacteria in the body] used to treat complicated urinary tract infections [UTI- an infection in any part of the urinary tract, the system of organs that makes urine]).</p> <p>As a result of this failure, RP 2 was not informed timely of the change in Resident 2's treatment and plan of care. This failure caused a delay in providing the necessary care and services to Resident 2.</p> <p>Findings:</p> <p>During a review of Resident 2's Admission Record (AR), the AR indicated the facility admitted Resident 2 on 1/7/2025, with diagnoses that included UTI and Carrier of CRE (CRE- a group of bacteria that are resistant to certain antibiotics and can cause serious infections).</p> <p>During a review of Resident 2's Physician Order (PO) dated 1/8/2025, the PO indicated Resident 2 had an order to discontinue ceftazidime-avibactam (Avycaz) intravenous (IV- soft, flexible tube placed inside a vein to administer fluids and medication directly to the bloodstream) solution 2.5 gm every eight hours on 1/8/2025, and to repeat urinalysis (UA- a medical test that examines a person's urine to detect and diagnose different health conditions) with culture and sensitivity (C&S- lab test that identifies the cause of an infection and helps determine the best treatment) on 1/9/2025.</p> <p>During a review of Resident 2's PO dated 1/12/2025, the PO indicated Resident 2 had an order to collect urinalysis due to (Resident 2's) confusion.</p> <p>During a review of Resident 2's PO dated 1/13/2025, the PO indicated Resident 2 had an order to transfer Resident 2 to GACH 1 for AMS.</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 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a review of Resident 2's Transfer Form (TF- Transfer to Hospital Form) dated 1/13/2025, timed at 11:27 am, the TF indicated Resident 2 was noted with AMS and would be transferred to GACH 1.</p> <p>During a review of Resident 2's GACH 1 Emergency Department (ED) Provider Note (EDPN) dated 1/13/2025, timed at 2:01 pm, the EDPN indicated Resident 2 was brought in by emergency medical services (EMS- refers to a system that provides immediate medical care to individuals in emergency situations) due to increased confusion and abnormal laboratory test results. The EDPN indicated Resident 2 was sent to GACH 1 ED to determine alternative antibiotic to treat Resident 2's Pseudomonas UTI. The EPDN indicated Resident 2 was started on ceftazidime-avibactam and discharged from GACH 1 on 1/7/2025 (to Skilled Nursing Facility [SNF] 1) to continue the antibiotics therapy (ceftazidime-avibactam). The EDPN indicated because of the high cost of the antibiotics (ceftazidime-avibactam), SNF 1 had not given the antibiotics (ceftazidime-avibactam) to Resident 2 since Resident 2 was discharged from GACH 1 to SNF 1 (on 1/7/2025).</p> <p>During a review of Resident 2's GACH 1 Triage (process by which care providers such as medical professionals determine the order of priority for providing treatment) Note ED (TNED), dated 1/13/2025, timed at 2:15 pm, the TNED indicated Resident 2 was brought in by ambulance for increased confusion that started yesterday (1/12/2024), with elevated white blood cells (cells in the blood that indicate if an infection is present) and UTI.</p> <p>During an interview on 1/29/2025 at 11:10 am with the Administrator (ADM), the ADM stated Resident 2 was admitted to the facility for IV antibiotics therapy for treatment of complicated CRE. The ADM stated Resident 2 was on antibiotics called Avycaz. The ADM stated on 1/12/2025, RP 2 called the ADM and stated RP 2 had not been notified MD 1 discontinued Resident 2's Avycaz at SNF 1. The ADM stated facility staff (unidentified) did not notify RP 2 regarding MD 1 discontinuing the Avycaz at SNF 1 because facility staff assumed MD 1 notified RP 2.</p> <p>During a concurrent interview and record review on 1/29/2025 at 12:49 pm with LVN 2, Resident 2's PO dated 1/8/2025 and Progress Notes (PN) for 1/2025 were reviewed. The PN indicated no documentation that RP 2 was notified regarding Resident 2's Avycaz being discontinued on 1/8/2025. LVN 1 stated (in general), when a physician ordered licensed nurses to discontinue a medication, licensed nurses were supposed to call the resident's family/responsible party, so the family/responsible party was updated on the plan of care and was not left, wondering what was going on.</p> <p>During a concurrent telephone interview and record review on 1/29/2025 at 3:59 pm with MD 1, Resident 2's PO dated 1/8/2025 was reviewed. MD 1 stated Resident 2 was admitted to the facility for treatment of Pseudomonas-resistant bacteremia (bacteria in the blood). MD 1 stated MD 1 ordered another urinalysis with C&S the day MD 1 discontinued the ceftazidime-avibactam (Avycaz on 1/8/2025). MD 1 stated MD 1 ordered another urinalysis with C&S on the same day (1/8/2025) to see if another antibiotic would be effective. MD 1 stated MD 1 did not notify RP 2 on 1/8/2025 when MD 1 discontinued the Avycaz because MD 1, expected the facility to do it.</p> <p>(continued on next page)</p>		

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<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a telephone interview on 1/30/2025 at 10:31 am with RP 2, RP 2 stated Resident 2 was supposed to be admitted to the facility on [DATE] to complete a course of IV antibiotics for treatment of a very complicated UTI through 1/13/2025. RP 2 stated Resident 2 was supposed to be discharged home upon completion of the antibiotics. RP 2 stated when MD 1 discontinued Avycaz on 1/8/2025, RP 2 was not notified by the facility or by MD 1. RP 2 stated RP 2 was notified Avycaz had been discontinued on 1/12/2025 (4 days later). RP 2 stated Resident 2 had not been given any alternative treatment for Resident 2's UTI when Avycaz was discontinued on 1/8/2025. RP 2 stated Resident 2 was in pain, confused and was not communicated with regarding treatment of Resident 2's UTI. RP 2 stated RP 2 did not understand how the facility accepted Resident 2 as a resident when the facility was not going to carry out GACH 1's instructions.</p> <p>During an interview and record review on 1/30/2025 at 11:39 am with the Director of Nursing, Resident 2's PN from 1/8/2025 to 1/12/2025 and PO dated 1/8/2025 were reviewed. The DON stated on 1/8/2025, the DON found out MD 1 discontinued Resident 2's Avycaz order even though Resident 2 was admitted to the facility for IV antibiotics therapy. The DON stated the DON did not question why MD 1 discontinued the Avycaz even though no alternative treatment was ordered. The DON stated RP 2 should have been notified when MD 1 discontinued Avycaz.</p> <p>During a telephone interview on 1/30/2025, timed at 3:21 pm with Resident 2, Resident 2 stated facility did not talk to Resident 2 about what the plan was for Resident 2's UTI. Resident 2 stated Resident 2's experience at the facility made him feel, really lousy and pushed aside. Resident 2 stated, if was not for my daughter, nothing would have done.</p> <p>During a review of the facility's P&P titled, Change in a Resident's Condition or Status, revised 5/2017, the P&P indicated, Our facility shall promptly notify the resident, his or her attending physician, and representative (sponsor) of changes in the resident's medical/mental condition and/or status (e.g. changes in level of care, billing/payments, resident rights, etc.). The P&P indicated, Unless otherwise instructed by the resident, a nurse will notify the resident's representative when: there is a significant change in the resident's physical, mental, or psychosocial status .</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46687</p> <p>Based on interview and record review, the facility failed to provide care and services for one of three residents (Resident 2), according to the facility's policy and procedures titled, Antibiotic Stewardship (the effort to measure and improve how antibiotics [medicine that stops the growth of or destroys bacteria in the body]) - Orders for Antibiotics, and Urinary Tract Infection (UTI- an infection in any part of the urinary tract, the system of organs that makes urine)/Bacteriuria (bacteria in urine), by failing to:</p> <ol style="list-style-type: none"> 1. Ensure Resident 2's Primary Care Provider/Medical Doctor (MD) 1 continued Resident 2's intravenous (IV- soft, flexible tube placed inside a vein to administer fluids and medication directly to the bloodstream) ceftazidime-avibactam (Avycaz- an antibiotic used to treat a wide variety of bacterial infections) therapy for the treatment of Resident 2's Pseudomonas aeruginosa (Pseudomonas- a type of bacteria that are widely found in the environment that can cause infection in the body) UTI as recommended by the General Acute Care Hospital (GACH 1) Inpatient Infectious Disease Medical Doctor (MD 2- a physician who specializes in the treatment of infectious diseases)) or provided alternative treatment 2. Ensure assigned licensed nurses (Licensed Vocational Nurses [LVNs] and/or Registered Nurses [RNs]) carried out (to do or complete) a physician order dated 1/8/2025 for a urinalysis (UA- a medical test that examines a person's urine to detect and diagnose different health conditions) with culture and sensitivity (C&S- lab test that identifies the cause of an infection and helps determine the best treatment) to be obtained on 1/9/2025 <p>As a result of these failures, Resident 2 did not receive the needed antibiotics therapy to treat Resident 2's Pseudomonas UTI from 1/8/2025 to 1/12/2025. On 1/13/2025, at 1:40 pm, Resident 2 experienced altered mental status (AMS- change in a person's level of consciousness, awareness, or cognitive function [ability to think, process information and make decisions]) and was transferred to the General Acute Care Hospital (GACH) 1 for further evaluation and treatment.</p> <p>Cross Reference F770</p> <p>Findings:</p> <p>During a review of Resident 2's Admission Record (AR), the AR indicated the facility admitted Resident 2 on 1/7/2025, with diagnoses that included UTI and carrier of CRE Carbapenem-resistant Enterobacterales (CRE- a group of bacteria that are resistant to certain antibiotics and can cause serious infections).</p> <p>During a review of Resident 2's Order Reconciliation Manager Discharge (ORMD- the process of reviewing the patient's complete medication regimen at the time of transfer/discharge and comparing it with the regimen being considered for the new setting of care) from GACH 1 dated 1/7/2025, timed at 1:31 pm, the ORMD indicated active medications at time of discharge reconciliation included ceftazidime-avibactam (Avycaz) 2.5 gram (gm- unit of measurement) IV injection.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a review of Resident 2's GACH 1 Referral Packet for Skilled Nursing Facility (SNF 1) Admission (HRP) dated 1/7/2025, timed at 2:44 pm, the HRP indicated discharge orders for Resident 2 which included IV antibiotics at SNF 1, Avycaz 2.5 gm IV every eight hours until 1/13/2025.</p> <p>During a review of Resident 2's Admission Assessment (AA) dated 1/7/2025, timed at 9:40 pm, the AA indicated Resident 2 was on isolation (a type of infection control precaution used to prevent the spread of infection) and noted to have an antibiotic treatment order for ceftazidime-avibactam (Avycaz) IV solution reconstituted 2.5 gm and to administer 2.5 gm intravenously every eight hours for UTI.</p> <p>During a review of Resident 2's Interim Medication Regimen Review (IMMR) from SNF 1's Outside Pharmacy (OP) 1, the IMMR indicated Resident 2 was a new admission to SNF 1 and there were no recommendations given by the reviewing pharmacist.</p> <p>During a review of Resident 2's Physician Order (PO) dated 1/7/2025, the PO indicated Resident 2 had an order to admit (Resident 2) to SNF 1 under the direction of MD 1.</p> <p>During a review of Resident 2's PO dated 1/8/2025, the PO indicated Resident 2 had an order to discontinue ceftazidime-avibactam (Avycaz) IV solution 2.5 gm every eight hours on 1/8/2025, and to repeat urinalysis with C&S on 1/9/2025.</p> <p>During a review of Resident 2's PO, dated 1/8/2025, the PO indicated Resident 2 had an order for urinalysis with C&S on 1/9/2025 (indication was not specified).</p> <p>During a review of Resident 2's PO dated 1/12/2025, the PO indicated Resident 2 had an order to collect urinalysis due to (Resident 2's) confusion.</p> <p>During a review of Resident 2's PO dated 1/13/2025, the PO indicated Resident 2 had an order to transfer Resident 2 to GACH 1 for AMS.</p> <p>During a review of Resident 2's Transfer Form (TF- Transfer to Hospital Form) dated 1/13/2025, timed at 11:27 am, the TF indicated Resident 2 was noted with AMS and would be transferred to GACH 1.</p> <p>During a review of Resident 2's Progress Notes (PN) dated 1/13/2025, timed at 1:40 pm, the PN indicated Resident 2 was transferred to GACH 1 due to AMS.</p> <p>During a review of Resident 2's GACH 1 Emergency Department (ED) Provider Note (EDPN) dated 1/13/2025, timed at 2:01 pm, the EDPN indicated Resident 2 was brought in by emergency medical services (EMS- refers to a system that provides immediate medical care to individuals in emergency situations) due to increased confusion and abnormal laboratory test results. The EDPN indicated Resident 2 was sent to GACH 1 ED to determine alternative antibiotic to treat Resident 2's Pseudomonas UTI. The EPDN indicated Resident 2 was started on ceftazidime-avibactam and discharged from GACH 1 on 1/7/2025 (to Skilled Nursing Facility [SNF] 1) to continue the antibiotics therapy (ceftazidime-avibactam). The EDPN indicated because of the high cost of the antibiotics (ceftazidime-avibactam), SNF 1 had not given the antibiotics (ceftazidime-avibactam) to Resident 2 since Resident 2 was discharged from GACH 1 to SNF 1 (on 1/7/2025). The EDPN indicated Resident 2 would receive a dose of ceftazidime-avibactam in GACH 1 ED. The EDPN indicated MD 1 would coordinate with SNF 1 to ensure Resident 2 received the antibiotics (ceftazidime-avibactam) at SNF 1.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a review of Resident 2's GACH 1 Triage (process by which care providers such as medical professionals determine the order of priority for providing treatment) Note ED (TNED), dated 1/13/2025, timed at 2:15 pm, the TNED indicated Resident 2 was brought in by ambulance for increased confusion that started yesterday (1/12/2024), with elevated white blood cells (cells in the blood that indicate if an infection is present) and UTI.</p> <p>During an interview on 1/29/2025 at 11:10 am with the Administrator (ADM), the ADM stated Resident 2 was admitted to the facility for IV antibiotics therapy for treatment of complicated CRE. The ADM stated Resident 2 was on antibiotics called Avycaz. The ADM stated MD 1 discontinued Avycaz but did not discuss the reason and did not put Resident 2 on any alternative antibiotics.</p> <p>During a concurrent interview and record review on 1/29/2025, timed at 1:21 pm, with RN 1, Resident 2's PN from 1/8/2025 to 1/12/2025 and PO dated 1/8/2025 were reviewed. RN 1 stated Resident 2 was admitted to the facility on [DATE] for IV antibiotics therapy. RN 1 stated RN 1 was Resident 2's admitting nurse. RN 1 stated RN 1 expected Resident 2's Avycaz to be delivered by OP 1 on 1/8/2025. RN 1 stated RN 1 received information on 1/8/2025 that MD 1 discontinued Resident 2's Avycaz order. RN 1 stated MD 1 did not order an alternative treatment and/or antibiotics for Resident 2. RN 1 stated (in general) RN 1 would never accept an order from a physician to discontinue a medication because it was too expensive. RN 1 stated (in general) if RN 1 carried out a discontinuation order for antibiotics because it was too expensive, the resident could get sicker and require rehospitalization, which could affect their health in a negative way. RN 1 stated a resident's infection could get worse and cause complications that make them sicker.</p> <p>During a concurrent telephone interview and record review on 1/29/2025 at 3:59 pm with MD 1, Resident 2's PO dated 1/8/2025 was reviewed. MD 1 stated Resident 2 was admitted to the facility for treatment of Pseudomonas-resistant bacteremia (bacteria in the blood) that included IV antibiotics therapy with Avycaz. MD 1 stated MD 1 ordered another urinalysis with C&S the day MD 1 discontinued the ceftazidime-avibactam (Avycaz on 1/8/2025) due to the high cost of the ceftazidime-avibactam (Avycaz). MD 1 stated MD 1 ordered another urinalysis with C&S on the same day (1/8/2025) to see if another antibiotic would be effective. MD 1 stated Resident 2 did not receive any antibiotics or other treatment at SNF 1 for Resident 2's UTI from 1/8/2025 through 1/12/2025 and until 1/13/2025, when Resident 2 was transferred to GACH 1 for AMS. MD 1 stated AMS was a symptom of infection. MD 1 stated Resident 2 was readmitted to SNF 1 on 1/13/2025 with another order for ceftazidime-avibactam (Avycaz) to be given until 1/16/2025. MD 1 stated it was important for Resident 2 to get the antibiotics needed and to finish the ordered course of antibiotics to treat (any) bacterial infection, otherwise the infection could get worse, and Resident 2 could end up in the hospital and the infection could lead to death. MD 1 stated if MD 1 ordered labs (in general), the labs needed to be obtained as soon as possible so they (MD 1 and facility staff) could appropriately treat Resident 2. MD 1 stated not obtaining Resident 2's urinalysis with C&S as soon as possible caused a delay in Resident 2's care which resulted in Resident 2's rehospitalization (readmitted to the hospital for a second time).</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a telephone interview on 1/30/2025 at 11:25 am with Pharm 1, Pharm 1 stated OP 1 managed the fulfillment of prescriptions for SNF 1. Pharm 1 stated OP 1 delivered IV medications including antibiotics. Pharm 1 stated OP 1 carried Avycaz but it was expensive at \$514 per vial without insurance coverage. Pharm 1 stated Avycaz generally required prior authorization (a process that requires health insurance approval before a service or prescription can be covered requested by a physician) because of its price. Pharm 1 stated (in general) if prior authorization was not obtained by a physician, then the recipient of Avycaz or providing facility would have to pay full price. Pharm 1 stated MD 1 did not obtain prior authorization for Resident 2 to be on Avycaz. Pharm 1 stated pharmacy staff (unidentified) from OP 1 called MD 1 to discuss the medication (Avycaz) after receiving an order for it (Avycaz) from the facility on 1/7/2025. Pharm 1 stated on 1/8/2025 at 4:28 am, MD 1 discontinued Resident 2's Avycaz due to the cost.</p> <p>During a telephone interview on 1/30/2025 at 10:31 am with RP 2, RP 2 stated Resident 2 was supposed to be admitted to the facility on [DATE] to complete a course of IV antibiotics through 1/13/2025 for treatment of a very complicated UTI. RP 2 stated Resident 2 was supposed to be discharged home upon completion of the antibiotics therapy. RP 2 stated Resident 2 had not been given any alternative treatment for Resident 2's UTI when Avycaz was discontinued on 1/8/2025. RP 2 stated MD 1 informed RP 2 that Avycaz, cost almost \$1,000 per vial and no facility would have covered it. RP 2 stated Resident 2 had to be transferred to the ED on 1/13/2025. RP 2 stated Resident 2 had to be readmitted to SNF 1 for four more days to complete a course of Avycaz that was supposed to be completed on 1/13/2025. RP 2 stated Resident 2 was in pain, confused and was not communicated with regarding treatment of Resident 2's UTI. RP 2 stated RP 2 did not understand how the facility accepted Resident 2 as a resident when the facility was not going to carry out GACH 1's instructions (discharge orders).</p> <p>During an interview and record review on 1/30/2025 at 11:39 am with the Director of Nursing, Resident 2's PN from 1/8/2025 to 1/12/2025 and PO dated 1/8/2025 were reviewed. The DON stated (in general) the facility would review discharging instructions from discharging GACH for residents and should continue the discharge orders/instructions because residents were generally admitted to the facility to continue the care provided at the hospital in a less acute setting. The DON stated when MD 1 ordered a urine sample for urinalysis with C&S to be obtained on 1/9/2025, the urine sample needed to be collected that day (1/9/2025), so there was no delay in care. The DON stated Resident 2 experienced a delay in care (did not receive IV antibiotics for 5 days) because Resident 2's urinalysis with C&S was not carried out as ordered by MD 1. RN 1 stated as a result of missing Resident 2's urinalysis with C&S, Resident 2 did not receive any other treatment to treat Resident 2's UTI. The DON stated on 1/8/2025, the DON found out MD 1 discontinued Resident 2's Avycaz order even though Resident 2 was admitted to the facility for IV antibiotics therapy. The DON stated the DON did not question why MD 1 discontinued the Avycaz even though no alternative treatment was ordered. The DON stated because Resident 2 was admitted for IV antibiotics therapy and was not given the Avycaz as instructed by GACH 1 on admission, Resident 2's infection did not resolve, Resident 2 developed AMS, and required further evaluation at GACH 1 on 1/13/2025. The DON stated Resident 2's unresolved UTI, AMS, and rehospitalization could have been avoided had Resident 2 been given Avycaz as instructed by GACH 1.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a telephone interview on 1/30/2025, timed at 3:21 pm, with Resident 2, Resident 2 stated facility did not talk to Resident 2 about what the plan was for Resident 2's UTI. Resident 2 stated Resident 2's experience at the facility made him feel, really lousy and pushed aside. Resident 2 stated, if was not for my daughter, nothing would have done. Resident 2 stated when Resident 2 had to go back to the hospital, and again to the facility instead of being discharged home on 1/13/2025, Resident 2, wanted everything to end. Resident 2 stated, I wished it was over, and I had a pistol to end it right there.</p> <p>During a review of the facility's P&P titled, Antibiotic Stewardship- Orders for Antibiotics, revised 12/2016, the P&P indicated, Antibiotics will be prescribed and administered to residents under the guidance of the facility's Antibiotic Stewardship Program and in conjunction with the facility's general policy for Medication Utilization and Prescribing. The P&P indicated, Appropriate indications for use of antibiotics included . Criteria met for clinical definition of active infection or suspected sepsis; and Pathogen (bacteria) susceptibility, based on culture and sensitivity to antimicrobial (antibiotics) (or therapy begun while culture is pending). The P&P indicated, When a resident is admitted from an emergency department, acute care facility, or other care facility, the admitting nurse will review the discharge and transfer paperwork for current antibiotic/anti-infective orders. Discharge or transfer medical records must include all of the above drug and dosing elements.</p> <p>During a review of the facility's P&P titled, UTI/Bacteriuria- Clinical Protocol, revised 4/2018, the P&P indicated, The physician and staff will identify individuals with a history of symptomatic urinary tract infections, and those who have risk-factors for UTIs. The P&P indicated, The physician will order appropriate treatment for verified or suspected UTIs . based on a pertinent assessment. The P&P indicated, Generally, symptomatic UTIs should be treated The P&P indicated, The physician and nursing will review the status of individuals who are being treated for a UTI and adjust treatment accordingly.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555729	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/30/2025
NAME OF PROVIDER OR SUPPLIER Arcadia Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1601 S Baldwin Ave. Arcadia, CA 91007	
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 0770</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Provide timely, quality laboratory services/tests to meet the needs of residents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46687</p> <p>Based on interview and record review, the facility failed to provide the laboratory (a room or building equipped for experimental study in science or for testing and analysis) services (laboratory services/laboratory tests included certain blood tests and urinalysis [UA- a medical test that examines a person's urine to detect and diagnose different health conditions], that helped healthcare professionals to detect and treat diseases) for one of three sampled residents (Resident 2) according to the facility's policy and procedures (P&P) titled, Lab and Diagnostic Test Results - Clinical Protocol, by failing to:</p> <p>Ensure assigned licensed nurses (Licensed Vocational Nurses [LVNs] and/or Registered Nurses [RN] carried out (to do or complete) a physician order dated 1/8/2025 for a UA with culture and sensitivity (C&S- a laboratory test that checks for bacteria or other germs in a urine sample that can cause an infection and checks to see what kind of antibiotic [a medicine that stops the growth of or destroys microorganism], will work best to treat the illness or infection) for the treatment of Resident 2's Pseudomonas aeruginosa (Pseudomonas- a type of bacteria that are widely found in the environment that can cause infection on the skin, blood, lungs, and other parts of the body) urinary tract infection (UTI- an infection in any part of the urinary tract, the system of organs that makes urine), as ordered by Resident 2's Primary Care Provider/Medical Doctor (MD) 1.</p> <p>As a result of this failure, Resident 2 did not receive the needed antibiotics therapy to treat Resident 2's Pseudomonas UTI from 1/8/2025 to 1/12/2025. On 1/13/2025, at 1:40 pm, Resident 2 experienced altered mental status (AMS- change in a person's level of consciousness, awareness, or cognitive function [ability to think, process information and make decisions] and was transferred to the General Acute Care Hospital (GACH) 1 for further evaluation and treatment.</p> <p>Cross Reference F684</p> <p>Findings:</p> <p>During a review of Resident 2's Admission Record (AR), the AR indicated the facility admitted Resident 2 on 1/7/2025, with diagnoses that included UTI and carrier of Carbapenem-resistant Enterobacterales (CRE- a group of bacteria that are resistant to certain antibiotics and can cause serious infections).</p> <p>During a review of Resident 2's Physician Order (PO) dated 1/8/2025, the PO indicated Resident 2 had an order to discontinue ceftazidime-avibactam (Avycaz- medication used to treat a wide variety of bacterial infections) intravenous (IV- a method of delivering fluids or medicine directly into a vein using a needle or tube) solution 2.5 gram (gm- unit of measurement) every eight (8) hours on 1/8/2025, and to repeat urinalysis with C&S on 1/9/2025.</p> <p>During a review of Resident 2's PO, dated 1/8/2025, the PO indicated Resident 2 had an order for urinalysis with C&S on 1/9/2025 (indication was not specified).</p> <p>During a review of Resident 2's PO dated 1/12/2025, the PO indicated Resident 2 had an order to collect urinalysis due to (Resident 2's) confusion.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555729	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/30/2025
NAME OF PROVIDER OR SUPPLIER Arcadia Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1601 S Baldwin Ave. Arcadia, CA 91007	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0770</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>During a review of Resident 2's PO dated 1/13/2025, the PO indicated Resident 2 had an order to transfer Resident 2 to GACH 1 for AMS.</p> <p>During a review of Resident 2's Transfer Form (TF- Transfer to Hospital Form) dated 1/13/2025, timed at 11:27 am, the TF indicated Resident 2 was noted with AMS and would be transferred to GACH 1.</p> <p>During a review of Resident 2's Progress Notes (PN) dated 1/13/2025, timed at 1:40 pm, the PN indicated Resident 2 was transferred to GACH 1 due to AMS.</p> <p>During a review of Resident 2's GACH 1 Emergency Department (ED) Provider Note (EDPN) dated 1/13/2025, timed at 2:01 pm, the EDPN indicated Resident 2 was brought in by emergency medical services (EMS- refers to a system that provides immediate medical care to individuals in emergency situations) due to increased confusion and abnormal laboratory test results. The EDPN indicated Resident 2 was sent to GACH 1 ED to determine alternative antibiotic to treat Resident 2's Pseudomonas UTI. The EDPN indicated Resident 2 was started on ceftazidime-avibactam and discharged from GACH 1 on 1/7/2025 (to Skilled Nursing Facility [SNF] 1) to continue the antibiotics therapy (ceftazidime-avibactam). The EDPN indicated because of the high cost of the antibiotics (ceftazidime-avibactam), SNF 1 had not given the antibiotics (ceftazidime-avibactam) to Resident 2 since Resident 2 was discharged from GACH 1 to SNF 1 (on 1/7/2025). The EDPN indicated Resident 2 would receive a dose of ceftazidime-avibactam in GACH 1 ED. The EDPN indicated MD 1 would coordinate with SNF 1 to ensure Resident 2 received the antibiotics (ceftazidime-avibactam) at SNF 1.</p> <p>During a review of Resident 2's GACH 1 Triage (process by which care providers such as medical professionals determine the order of priority for providing treatment) Note ED (TNED), dated 1/13/2025, timed at 2:15 pm, the TNED indicated Resident 2 was brought in by ambulance for increased confusion that started yesterday (1/12/2024), with elevated white blood cells (cells in the blood that indicate if an infection is present), and UTI.</p> <p>During a concurrent interview and record review on 1/29/2025 at 1:21 pm with RN 1, Resident 2's PN from 1/8/2025 to 1/12/2025 and active PO dated 1/8/2025 were reviewed. The PO dated 1/8/2025 indicated for facility staff to obtain a urinalysis with C&S from Resident 2 on 1/9/2025. Resident 2's PN from 1/8/2025 to 1/12/2025 indicated no documentation facility staff attempted to collect a urine sample from Resident 2 to carry out Resident 2's physician order to obtain a urinalysis with C&S on 1/9/2025. RN 1 stated Resident 2 was admitted to the facility on [DATE] for IV antibiotics (ceftazidime-avibactam) therapy. RN 1 stated RN 1 was Resident 2's admitting nurse. RN 1 stated if MD 1 ordered laboratory tests (labs) for Resident 2, the order needed to be carried out as soon as possible. RN 1 stated there was no documentation in Resident 2's PN indicating Resident 2's urine sample was collected/obtained for the urinalysis with C&S as indicated in Resident 2's physician order. RN 1 stated Resident 2 had a delay in care and did not receive any antibiotics or other treatment at SNF 1 for Resident 2's UTI (from 1/8/2025 to 1/12/2025).</p> <p>(continued on next page)</p>

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NAME OF PROVIDER OR SUPPLIER Arcadia Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1601 S Baldwin Ave. Arcadia, CA 91007	

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<p>F 0770</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>During a concurrent telephone interview and record review on 1/29/2025 at 3:59 pm with MD 1, Resident 2's PO dated 1/8/2025 was reviewed. MD 1 stated Resident 2 was admitted to the facility for treatment of Pseudomonas-resistant bacteremia (bacteria in the blood). MD 1 stated MD 1 ordered another urinalysis with C&S the day MD 1 discontinued the ceftazidime-avibactam (Avycaz on 1/8/2025) due to the high cost of the ceftazidime-avibactam (Avycaz). MD 1 stated MD 1 ordered another urinalysis with C&S on the same day (1/8/2025) to see if another antibiotic would be effective. MD 1 stated Resident 2 did not receive any antibiotics or other treatment at SNF 1 for Resident 2's UTI from 1/8/2025 through 1/12/2025 and until 1/13/2025, when Resident 2 was transferred to GACH 1 for AMS. MD 1 stated AMS was a symptom of infection. MD 1 stated Resident 2 was readmitted to SNF 1 on 1/13/2025 with another order for ceftazidime-avibactam (Avycaz) to be given until 1/16/2025. MD 1 stated if MD 1 ordered labs (in general), the labs needed to be obtained as soon as possible so they (MD 1 and facility staff) could appropriately treat Resident 2. MD 1 stated not obtaining Resident 2's urine sample for urinalysis with C&S as soon as possible caused a delay in Resident 2's care which resulted in Residents 2's rehospitalization (readmitted to the hospital for a second time).</p> <p>During an interview and concurrent record review on 1/30/2025 at 11:10 am with LVN 1, Resident 2's PO dated 1/8/2025 was reviewed. Resident 2's PO dated 1/8/2025, indicated Resident 2 had an order for urinalysis with C&S to be obtained on 1/9/2025. LVN 1 stated Resident 2's care was not up to par, and Resident 2 did not receive the needed antibiotics (ceftazidime-avibactam) to treat Resident 2's UTI.</p> <p>During an interview and record review on 1/30/2025 at 11:39 am with the Director of Nursing (DON), Resident 2's PO dated 1/8/2025 was reviewed. Resident 2's PO dated 1/8/2025, indicated Resident 2 had an order for urinalysis with C&S to be obtained on 1/9/2025. The DON stated when MD 1 ordered a urine sample for urinalysis with C&S to be obtained on 1/9/2025, the urine sample needed to be collected that day (1/9/2025), so there was no delay in care. The DON stated Resident 2 experienced a delay in care (did not receive IV antibiotics for 5 days) because Resident 2's urinalysis with C&S was not carried out as ordered by MD 1. The DON stated as a result of missing Resident 2's urinalysis with C&S, Resident 2 did not receive any other treatment to treat Resident 2's UTI.</p> <p>During a review of the facility's P&P titled, Lab and Diagnostic Test Results - Clinical Protocol, revised 11/2018 (most updated), the P&P indicated, The physician will identify and order diagnostic and lab testing on the resident's diagnostic and monitoring needs. The staff will process test requisitions and arrange for tests. The P&P indicated, A nurse will try to determine whether the test was done .as a routine screen or follow-up .</p>