STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555729	A. Building B. Wing	02/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Arcadia Care Center	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)
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. 37198 Based on interview and record review, the facility failed to follow its policy and procedure (P&P) titled, Change in a Resident's Condition or Status, by not notifying one of two sampled residents' (Resident 1's) Representative (R1) when Resident 1 was transferred to the General Acute Care Hospital (GACH 1). This failure resulted in the violation of Resident 1's and R1's right to be notified of any changes of condition/status of Resident 1. Cross Reference F842 Findings: During a review of Resident 1's Admission Record (AR), the AR indicated the facility originally admitted Resident 1 on 1/13/2025, and readmitted Resident 1 on 2/6/2025, with diagnoses that included encephalopathy (damage or disease that affects the brain), acute respiratory failure with hypoxia (a condition where the lungs do not get enough oxygen into the blood, resulting in low blood oxygen levels), and pneumonitis due to inhalation of food and vomit (a lung infection that occurs when you breathe in food or liquid instead of swallowing it). The AR indicated R1 was the first emergency contact person for Resident 1. During a review of Resident 1's Minimum Data Set (MDS - a resident assessment tool), dated 1/16/2025, the MDS indicated Resident 1 was rarely/never understood by others and rarely/never understood others. The MDS indicated Resident 1 was dependent (helper does all of the effort) on staff for showering/bathing self, upper and lower body dressing, putting on/taking off footwear, and oral, toileting, and personal hygiene. During a review of Resident 1's Progress Notes (PN), dated 1/29/2025, timed at 7:51 am, the PN indicated Resident 1 was discharged to the hospital. (continued on next page)

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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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 2/13/2025 at 1:57 pm with the Director of Staff Development (DSD), Resident 1's Transfer Form (TF) dated 1/29/2025 and timed at 1:12 am was reviewed. The TF indicated Resident 1 was transferred to GACH 1 at 2 am due to a respiratory infection (an infection affecting the nose, throat, airways, and lungs). The DSD stated the TF indicated Licensed Vocational Nurse (LVN) 1 transferred Resident 1 to GACH 1. The DSD stated the TF indicated the name of R1 as Resident 1's emergency contact but did not include the time LVN 1 notified R1. During an interview on 2/13/2025 at 2:29 pm with LVN 1, LVN 1 stated LVN 1 did not remember the time LVN 1 contacted R1 about Resident 1's transfer to GACH 1. During a concurrent interview and record review on 2/13/2025 at 2:41 pm with the DSD, the facility's Check-Logs ([CL] - the facility's visitor logs) were reviewed. The DSD stated the CL indicated R1 checked in and was in the facility on 1/29/2025 at 8:58 am, while Resident 1 was at GACH 1. During a concurrent interview and record review on 2/13/2025 at 2:45 pm with the Director of Nursing (DON), Resident 1's TF dated 1/29/2025 and timed at 1:12 am and PN dated 1/29/2025 were reviewed. The DON stated Resident 1's TF indicated Resident 1 was transferred to GACH 1 on 1/29/2025 at 1:12 am. The DON stated if LVN 1 did not document the notification to R1 in Resident 1's PN, LVN 1 could have documented it on Resident 1's TF under section 11 which indicated, additional relevant information. The DON stated, If it was not documented, it was not done. The DON stated notifications (to resident's representative) and whatever was relevant to the resident's condition needed to be documented on the TF. During a review of the facility's P&P titled, Change in a Resident's Condition or Status, revised May 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 . it is necessary to transfer the resident to a hospital/treatment center . The P&P indicated, The nurse will record the resident's medical record information relative to changes in the resident's medical/mental condition or status.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. 37198 Based on interview and record review, the facility failed to follow its policy and procedure (P&P) titled, Charting and Documentation, by failing to document notification to one of two sampled residents (Resident 1's) representative (R1) of Resident 1's transfer to the General Acute Care Hospital (GACH 1). This deficient practice had the potential to not provide complete information regarding Resident 1's transfer to GACH 1. Cross Reference F580 Findings: During a review of Resident 1's Admission Record (AR), the AR indicated the facility originally admitted Resident 1 on 1/13/2025, and readmitted Resident 1 on 2/6/2025, with diagnoses that included encephalopathy (damage or disease that affects the brain), acute respiratory failure with hypoxia (a condition where the lungs do not get enough oxygen into the blood, resulting in low blood oxygen levels), and pneumonitis due to inhalation of food and vomit (a lung infection that occurs when you breathe in food or liquid instead of swallowing it). The AR indicated R1 as the first emergency contact person for Resident 1. During a review of Resident 1's Minimum Data Set (MDS - a resident assessment tool), dated 1/16/2025, the MDS indicated Resident 1 was rarely/never understood by others and had the ability to rarely/never understand others. The MDS indicated Resident 1 was dependent (helper does all of the effort) on staff for showering/bathing self, upper and lower body dressing, putting on/taking off footwear, and oral, toileting, and personal hygiene. During a review of Resident 1's Progress Notes (PN), dated 1/29/2025, timed at 7:51 am, the PN indicated Resident 1 was discharged to the hospital. During a concurrent interview and record review on 2/13/2025 at 1:57 pm with the Director of Staff Development (DSD), Resident 1's Transfer Form (TF) dated 1/29/2025 and timed at 1:12 am was reviewed. The TF indicated Resident 1 was transferred to GACH 1 at 2 am due to a respiratory infection (an infection affecting the nose, throat, airways, and lungs). The DSD stated the TF indicated Licensed Vocational Nurse 1 (LVN) 1 transferred Resident 1 to GACH 1. The DSD stated the TF indicated the name of R1 as Resident 1's emergency contact but did not include the time LVN 1 notified R1. During an interview on 2/13/2025 at 2:29 pm with LVN 1, LVN 1 stated LVN 1 did not remember the time LVN 1 contacted R1 about Resident 1's transfer to GACH 1. (continued on next page)

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 2/13/2025 at 2:45 pm with the Director of Nursing (DON), Resident 1's TF dated 1/29/2025 and timed at 1:12 am and PN dated 1/29/2025 were reviewed. The DON stated Resident 1's TF indicated Resident 1 was transferred to GACH 1 on 1/29/2025 at 1:12 am. The DON stated if LVN 1 did not document the notification to R1 in Resident 1's PN, LVN 1 could have documented it on Resident 1's TF under section 11 which indicated, additional relevant information. The DON stated, If it was not documented, it was not done. The DON stated notifications (to resident's representative) and whatever was relevant to the resident's condition needed to be documented on the TF. During a review of the facility's undated P&P titled, Charting and Documentation, the P&P indicated All services provided to the resident, or any changes in the resident's medical or mental condition, shall be documented in the resident's medical record. The P&P indicated, Documentation of procedures and treatments shall include care-specific details and shall include at a minimum . Notification of family, physician or other staff, if indicated .