

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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Form Approved OMB
No. 0938-0391

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 07/23/2026
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)		
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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to promptly notify one of three sampled residents (Resident 1's) Responsible Party (RP) regarding Resident 1's increased heart rate and fever on 7/4/2026. This failure resulted in Resident 1's representatives not being informed of Resident 1's change in condition and not making an informed decision (decision based on facts, relevant information, and clear understanding of potential risks, benefits, and alternatives) regarding Resident 1's increased heart rate and fever. Findings: During a review of Resident 1's Face Sheet (FS), the FS indicated Resident 1 was admitted to the facility on [DATE] with diagnoses including left shoulder osteoarthritis (a progressive disorder of the joints, caused by a gradual loss of cartilage), hypertension (HTN-high blood pressure), and type 2 diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing). During a review of Resident 1's Minimum Data Set (MDS, a resident assessment tool) dated 5/12/2026, the MDS indicated Resident 1 had moderately impaired cognition (ability to make daily decisions). The MDS indicated Resident 1 required substantial/maximal assistance (helper does more than half the effort) for toileting hygiene, shower/bathe self, lower body dressing, and putting on/taking off footwear. The MDS indicated Resident 1 required partial/moderate assistance (helper does less than half the effort) for eating, upper body dressing, oral and personal hygiene. During a review of Resident 1's SBAR Communication Form (SBAR- situation, background, assessment, recommendation-a communication tool used by healthcare workers when there is a change of condition among the residents) dated 7/4/2026, the SBAR indicated Resident 1 had tachycardia (a fast heart rate more than 100 beats per minutes [bpm]) around 9:40 AM and fever around 12 PM. During a review of Resident 1's Progress Notes (PN) dated 7/4/2026, the PN indicated Resident 1 had tachycardia with fever and was sent out via 911 (emergency response) to General Acute Care Hospital 1 (GACH 1) on 7/4/2026. There was no documented evidence that Resident 1's RP was notified regarding Resident 1's tachycardia around 9:40 AM and fever around 12 PM on 7/4/2026. During a review of Resident 1's entire medical record, there was no documented evidence that Resident 1's RP was notified regarding Resident 1's tachycardia around 9:40 AM and fever around 12 PM on 7/4/2026. During a concurrent interview and record review on 7/22/2026 at 9:47 AM with Licensed Vocational Nurse 1 (LVN 1), Resident 1's SBAR dated 7/4/2026 was reviewed. LVN 1 stated Resident 1's RP was not notified when Resident 1 had abnormal increased heart rate on 7/4/2026 around 9:40 AM. LVN 1 stated LVN 1 did not notify Resident 1's RP when Resident 1 had a fever of 102.8 degrees Fahrenheit (F) on 7/4/2026 around 12 PM. LVN 1 stated the Resident 1's RP should have been notified when Resident 1 had any change of condition of tachycardia and fever. During an interview on 7/22/2026 at 4:55 PM with Registered Nurse 2 (RN 2), RN 2 stated RN 2 did not notify Resident 1's RP when Resident 1 had a change of (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	condition of increased heart rate more than 100 bpm on 7/4/2026 around 9:40 AM and a temperature of 102.8 F at 12 PM. During an interview on 7/23/2026 at 10:30 AM with Registered Nurse 3 (RN 3), RN 3 stated RN 3 did not notify Resident 1's RP when Resident 1 had a change of condition of increased abnormal heart rate on 7/4/2026 around 9:40 AM and fever of 102.8 F at 12 PM. RN 3 stated licensed nursing staff should notify the resident's RP promptly for any change of condition During a concurrent interview and record review on 7/23/2026 at 11:45 AM with the Director of Nursing (DON), Resident 1's SBAR dated 7/4/2026 was reviewed. The DON stated the facility should ensure nursing staff notify the resident's RP promptly about any change of condition. During a review of the facility's Policy and Procedure (P&P) titled, Change in a Resident's Condition or Status, revised 3/2025, the P&P indicated the 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. The P&P indicated, Notifications will be made to the party responsible when a change occurring in the resident's medical/mental condition or status.		

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F 0710 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Obtain a doctor's order to admit a resident and ensure the resident is under a doctor's care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure a physician or the facility's Medical Director promptly provided medical care to one of three sampled residents (Resident 1) when Resident 1's attending physician did not respond to Resident 1's change of condition of increased heart rate and fever on 7/4/2026. This failure had the potential for Resident 1 not to receive timely care and treatment and worsen Resident 1's condition. Findings: During a review of Resident 1's Face Sheet (FS), the FS indicated Resident 1 was admitted to the facility on [DATE] with diagnoses including left shoulder osteoarthritis (a progressive disorder of the joints, caused by a gradual loss of cartilage), hypertension (HTN-high blood pressure), and type 2 diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing). During a review of Resident 1's Minimum Data Set (MDS, a resident assessment tool) dated 5/12/2026, the MDS indicated Resident 1 had moderately impaired cognition (ability to make daily decisions). The MDS indicated Resident 1 required substantial/maximal assistance (helper does more than half the effort) for toileting hygiene, shower/bathe self, lower body dressing, and putting on/taking off footwear. The MDS indicated Resident 1 required partial/moderate assistance (helper does less than half the effort) for eating, upper body dressing, oral and personal hygiene. During a review of Resident 1's SBAR Communication Form (SBAR- situation, background, assessment, recommendation-a communication tool used by healthcare workers when there is a change of condition among the residents) dated 7/4/2026, the SBAR indicated Resident 1 had tachycardia (a fast heart rate more than 100 beats per minutes [bpm]) around 9:40 AM and the attending physician was notified but did not respond. The SBAR indicated Resident 1 had chills and fever of 102.8 degrees Fahrenheit (F) on 7/4/2026 around 12 PM and the attending physician was notified but did not respond. The SBAR did not indicate that the Medical Director or any physician was notified after there was no response from the attending physician. During a review of Resident 1's entire medical record, there was no documented evidence that the facility's Medical Director or any other physician was notified about Resident 1's tachycardia around 9:40 AM and fever around 12 PM after getting no response from Resident 1's attending physician on 7/4/2026. During a concurrent interview and record review on 7/22/2026 at 9:47 AM with Licensed Vocational Nurse 1 (LVN 1), Resident 1's SBAR dated 7/4/2026 was reviewed. LVN 1 stated the facility's Medical Director or any physician was not notified when Resident 1's attending physician did not respond regarding Resident 1's increased heart rate on 7/4/2026 around 9:40 AM. LVN 1 stated LVN 1 did not notify the facility's Medical Director or any other physician when Resident 1's attending physician did not respond regarding Resident 1's fever of 102.8 degrees Fahrenheit (F) on 7/4/2026 around 12 PM. During an interview on 7/22/2026 at 4:55 PM with Registered Nurse 2 (RN 2), RN 2 stated RN 2 did not notify any other facility physician when RN 2 did not get any response from Resident 1's attending physician regarding Resident 1's change of condition of increased heart rate more than 100 bpm on 7/4/2026 around 9:40 AM and fever of 102.8 F at 12 PM. RN 1 stated it was important to notify the physician of a resident's change of condition. During an interview on 7/23/2026 at 10:30 AM with Registered Nurse 3 (RN 3), RN 3 stated licensed nursing staff should notify the facility's Medical Director immediately if there was no response from the attending physician regarding a resident's significant change of condition. During a concurrent interview and record review on 7/23/2026 at 11:45 AM with the Director of Nursing (DON), Resident 1's SBAR dated 7/4/2026 was reviewed. The DON stated the facility should ensure nursing staff notify the resident's attending physician regarding any change of resident's condition or notify the facility's Medical (continued on next page)		

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F 0710 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Director promptly within one hour if there was no response from the attending physician. During a review of the facility's Policy and Procedure (P&P) titled, Change in a Resident's Condition or Status, revised 3/2025, the P&P indicated the 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, The nurse will notify the resident's Attending Physician or physician on call when there has been a significant change in the resident's physical/emotional/mental condition. During a review of the facility's P&P titled, Medical Director revised 7/2025, the P&P indicated the medical director functions also include but are not limited to help assure that residents receive adequate services appropriate to meet their needs and provide medical services if the resident's attending physician is not available or does not respond in a timely manner.		