STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555213	A. BUILDING _____ B. WING _____	03/06/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
PASADENA CARE CENTER, LLC	1640 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)
F 0552 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure that residents are fully informed and understand their health status, care and treatments.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to follow its policy and procedures on leaving the facility against medical advice (AMA) by attempting to discharge one of three sampled residents (Resident 1) without informing the resident in advance the risks of leaving the facility and allowing the resident to choose the alternative he preferred. This deficient practice violated the resident's right of self-determination. Findings: A review of Resident 1's Admission Record indicated the resident initially admitted to the facility on [DATE] with multiple [DIAGNOSES REDACTED]. to think, feel, and behave clearly and leads to faulty perception, inappropriate actions and feelings, and withdrawal from reality). A review of Resident 1's History & Physical Examination, dated 10/31/19, indicated the resident had the capacity to understand and make decisions. A review of Resident 1's Minimum Data Set (MDS, a standardized resident assessment and care-planning tool), dated 11/13/19, indicated the resident did not have an impairment in cognition (mental action or process of acquiring knowledge and understanding). A review of Resident 1's Order Summary Report, dated 1/1/2020 to 3/2/2020, indicated a physician's orders [REDACTED]. The physician's orders [REDACTED]. A review of Resident 1's Nurses Progress Notes, dated 1/6/2020 at 1:03 p.m., indicated the Director of Nursing (DON) received a call from a GACH nurse that Resident 1 was not at the hospital for his scheduled surgery. The DON documented that the morning charge nurse notified her that Resident 1 was picked up by somebody but Resident 1 did not take the GACH paperwork for the hospital appointment with him, which alerted the charge nurse that the resident might not have gone to his scheduled appointment. A review of the Social Services Note, dated 1/6/19 and timed at 1:39 p.m., indicated Social Services Director (SSD) noted Resident 1 was alert and oriented, able to make decisions of his own, and walked out of the facility, so the facility discharged him as AMA. A review of the physician's orders [REDACTED]. The note indicated NP 1 wrote an order to discharge Resident 1 AMA. During a telephone interview on 2/27/2020 at 2:56 p.m., Resident 1's Family Member 1 (FM 1) stated the facility was attempting to discharge Resident 1 on 1/6/2020 for leaving the facility against medical advice. FM 1 stated Resident 1 left the facility that morning because he was thinking he was running late for his scheduled surgery. FM 1 stated they tried to explain the situation to the SSD but she refused to admit Resident 1 because she stated she already discharged Resident 1 in the system. During a telephone interview on 3/2/2020 at 12:50 p.m., FM 2 stated they received a call from SSD after they found Resident 1 but before they got back to the facility. FM 2 stated SSD notified them she was going to discharge Resident 1 from the facility because he left AMA. FM 2 stated they asked if they could have a meeting with the facility staff and if there was any way the facility would not discharge Resident 1 until they figure out a way how and where Resident 1 was going to be transferred. FM 2 stated when they got to the facility on [DATE] at around 3 p.m., Resident 1's belongings were already placed in a bag. During an interview on 3/2/2020 at 1:01 p.m., Resident 1 stated on 1/6/2020, he was at the facility waiting for transportation from 7 a.m. to 8:10 a.m. Resident 1 stated he did not intend to permanently leave the facility unauthorized. Resident 1 stated he saw the bus across the street at 8:10 a.m. and decided to take it to go to GACH for his scheduled surgery. Resident 1 stated there was no staff member or a receptionist in the lobby and was trying to catch the bus. During an interview on 3/2/2020 at 2:28 p.m., the Director of Nursing (DON) stated the incident should have been considered as an elopement and that Resident 1 should not have been discharged AMA. A review of the facility's policy and procedures, titled Against Medical Advice (AMA) - Leaving the Community, dated 12/2014, indicated the: 1. Staff would notify the physician and have the resident sign the release forms in the event the resident desires to leave the facility against medical advice. 2. Licensed nurse must discuss the risks of leaving the facility against medical advice. 3. Licensed nurse must encourage the resident to consult with the attending physician if the resident continues to desire to leave the facility. 4. Licensed nurse would ensure the resident signs the Against Medical Advice (AMA) form.
F 0689 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to follow its policy and procedures on elopement risk precautions for one of three sampled residents (Resident 1). Resident 1 was at risk for elopement. Resident 1 had a scheduled surgery appointment on 1/6/2020 and the facility staff left the resident by himself in the downstairs lobby to wait for his transportation ride. This deficient practice resulted in the resident leaving the facility unauthorized, which had the potential to compromise the resident's safety. Findings: A review of Resident 1's Admission Record indicated the resident initially admitted to the facility on [DATE] with multiple [DIAGNOSES REDACTED]. to think, feel, and behave clearly and leads to faulty perception, inappropriate actions and feelings, and withdrawal from reality). A review of Resident 1's care plan titled, Resident is at risk for elopement, initiated on 11/26/2019, indicated the resident had an episode of going out of the facility without notifying the staff. A review of Resident 1's Elopement Risk Assessment, signed on 12/20/2019, indicated the resident was a high risk for elopement after the incident that occurred on 11/26/2019. A review of Resident 1's Order Summary Report, dated 1/1/2020 to 3/2/2020, indicated a physician's orders [REDACTED]. The physician's orders [REDACTED]. A review of Resident 1's Nurses Progress Notes, dated 1/6/2020 at 1:03 p.m., indicated the Director of Nursing (DON) received a call from a GACH nurse that Resident 1 was not at the hospital for his scheduled surgery. The DON documented that the morning charge nurse notified her that Resident 1 was picked up by somebody but Resident 1 did not take the GACH paperwork for the hospital appointment with him, which alerted the charge nurse that the resident might not have gone to his scheduled appointment. A review of Resident 1's Nurses Progress Note, dated 1/6/2020 at 1:14 p.m., indicated a Licensed Vocational Nurse 1 (LVN 1) documented that Resident 1 was missing after the staff changed shifts. LVN 1 documented that transportation staff did not arrive and/or notify the facility staff Resident 1 was picked up for his scheduled surgery on 1/6/2020 at 8 a.m. LVN 1 documented that the Social Services Director (SSD) was informed about what happened, and assisted in calling the transportation company to verify if Resident 1 was picked up. A review of Resident 1's Social Services Progress Notes, dated 1/6/2020 at 1:39 p.m., indicated the SSD called Resident 1's insurance company confirming that there was no transportation scheduled for Resident 1. During a telephone interview, on 2/27/2020 at 2:56 p.m., a Family Member 1 (FM 1) stated Resident 1 called her because the resident got lost on his way to the GACH for his scheduled surgery. FM 1 stated she picked up Resident 1 near a drug store in a different city because Resident 1's cellphone had a tracking system to find him. FM 1 stated that Resident 1 seemed to be alert and oriented, but would have periods of forgetfulness or confusion. During an interview, on 3/2/2020 at 11:59 a.m., LVN 1 stated Resident 1 was alert and oriented with periods of confusion. LVN 1 stated Resident 1 verbalized he wanted to go home, would get restless if

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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.

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F 0689 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 1) unable to leave the facility, and would hang out near the exit doors of the facility. LVN 1 stated on 1/6/2020 at around 7:30 a.m., Resident 1 was missing and asked other staff if anyone saw the resident. LVN 1 was unable to identify and/or recall any names of the staff involved in the search for Resident 1. LVN 1 stated he reported the incident to the SSD and DON, but he did not notify the local police or the Department of Public Health. LVN 1 stated the facility staff did not conduct a search outside of the facility or in the surrounding streets and/or yards. LVN 1 was unable to state the time when Resident 1 was located. During a telephone interview on 3/2/2020 at 12:50 p.m., FM 2 stated Resident 1 told her that he got anxious waiting for the transportation ride to the GACH because it did not arrive on time. FM2 stated that Resident 1 told her that a facility staff member told him to wait down stairs for the transportation ride. FM 2 stated she received a call from the facility on 1/6/2020 around 9 a.m. to inform her that Resident 1 was missing. FM 2 stated she called FM 1 to use Resident 1's cell phone tracking system to find Resident 1. During an interview on 3/2/2020 at 1:01 p.m., Resident 1 stated on 1/6/2020 that he was waiting on the second floor of the facility from 7 a.m. to 7:30 a.m. for his transportation ride to the GACH for his scheduled surgery at 8 a.m. Resident 1 stated at 7:30 a.m., a tall, female nurse (resident cannot recall name of nurse) from the 11 p.m. to 7 a.m. shift instructed him to go downstairs to wait for the transportation ride. Resident 1 stated the nurse did not escort him to the first floor. Resident 1 stated there was no staff and/or receptionist present on the first floor when he left the facility. Resident 1 stated at 8:10 a.m., he saw the bus across the street and decided to take it to get to the GACH. Resident 1 stated he realized shortly after that he did not know how to get to the GACH, so he decided to go to his previous residence to call FM 1. Resident 1 stated he was not able to get into his residence. Resident 1 stated that he was near a drug store in a different city around 10 a.m. and called FM 1. Resident 1 stated FM 1 picked him up around 11 a.m. During an interview on 3/2/2020 at 1:42 p.m., a Certified Nursing Assistant 1 (CNA 1) stated she worked on 1/6/2020 during the 7 a.m. to 3 p.m. shift. CNA 1 stated she does not recall being involved in the search for Resident 1. During an interview on 3/2/2020 at 1:58 p.m., CNA 2 stated she worked on 1/6/2020 during the 7 a.m. to 3 p.m. shift. CNA 2 stated she does not recall being involved in the search for Resident 1. During an interview on 3/2/2020 at 2:28 p.m., the DON stated on 1/6/2020 before 7:30 a.m. to 8 a.m., she received a call from the facility nurse stating Resident 1 was missing. The DON stated she instructed the facility nurse to recheck the facility. The DON was not sure if the facility staff notified Resident 1's physician and/or let all the staff know that Resident 1 was missing. The DON stated the facility did not notify the local police department about Resident 1 missing. The DON stated she called FM 2 between 10 a.m. to 12 p.m. because the facility could not find Resident 1. The DON stated that FM 2 informed her that Resident 1 was with her. The DON stated the facility staff were not aware that Resident 1 had a cellphone. The DON stated that the facility should have followed its policy and procedure for an elopement incident. During a telephone interview on 3/3/2020 at 8 a.m., CNA 6 stated Resident 1 always tried to leave the facility to go to his previous home. CNA 6 stated Resident 1 was alert and oriented, but would have periods of confusion when he would want to go out of the facility even if it was in the middle of the night. During telephone interview on 3/3/2020 at 10:21 a.m., CNA 7 stated when Resident 1 left the faciity on [DATE] and the search for Resident 1 was kind of unprofessional. CNA 7 stated there was no Code announced to indicate there was a missing person. CNA 7 stated she heard staff asking each other in the hallways and nurses' station if anyone has seen Resident 1, but she was not instructed to search for the resident. CNA 7 stated she did not know when the resident was found, and during a staff morning huddle (an informal meeting to get information about tasks/duties and/or information about the residents in the facility) the next day, the supervisor announced that Resident 1 was wandering and found outside of the facility. A review of the facility's policies and procedures titled, Elopement Risk Precautions and Procedures, dated 1/2013, indicated when a resident was missing, the facility would implement the following steps: 1. The Charge Nurse or designee must alert staff about the resident elopement or missing. 2. All employees must report to the nurse's station. 3. The Charge Nurse must explain the situation and designate where each staff person is to search. 4. Search the building: closets, showers, bathrooms, and grounds thoroughly. 5. If the facility search is unsuccessful, the surrounding streets and yards must be searched. 6. If the facility could not find the resident within two hours, notify the local Police, Administrator and responsible party. 7. The Charge Nurse/Supervisor/Administrator or Director of Nursing must call the family to explain the situation and let the family know what the facility was doing to find the resident. 8. When the resident was located, the charge nurse/supervisor would announce that the resident was found or located. 9. Upon return of the resident, the resident must be assessed for injuries and any physical or mental changes. The outcome of the evaluation must be documented in the medical record and in the care plan as needed. 10. The medical record must reflect an analysis of the events leading up to the elopement and the interventions to prevent another occurrence. Prevention methodologies must be reflected in the care plan.
F 0745 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide medically-related social services to help each resident achieve the highest possible quality of life.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to coordinate transportation to a general acute care hospital (GACH) for one of three sampled residents (Resident 1). Resident 1 had a scheduled surgery appointment on 1/6/2020 at a GACH for placement of an arteriovenous fistula (AV fistula, a connection of an artery to a vein made by a vascular surgeon). This deficient practice resulted in a delay in treatment due to a missed scheduled surgery. Findings: A review of Resident 1's Admission Record indicated the resident initially admitted to the facility on [DATE] with multiple [DIAGNOSES REDACTED]. to think, feel, and behave clearly and leads to faulty perception, inappropriate actions and feelings, and withdrawal from reality). A review of Resident 1's History & Physical Examination, dated 10/31/19, indicated Resident 1 had the capacity to understand and make decisions. A review of Resident 1's Order Summary Report, dated 1/1/2020 to 3/2/2020, indicated a physician's orders [REDACTED]. The physician's orders [REDACTED]. A review of Resident 1's Nurses Progress Note, dated 1/3/2020 at 3 p.m., indicated a Licensed Vocational Nurse 2 (LVN 2) received a call from the GACH regarding the procedure for Resident 1's [MEDICAL TREATMENT] access on 1/6/2020. Resident 1's nurse's note also indicated that Resident 1 needed to be at the GACH by 7 a.m. LVN 2 documented that the [MEDICAL TREATMENT] Center 1 arranged for Resident 1's transportation pick-up. A review of Resident 1's Social Services Progress Note, dated 1/3/2020 at 4:54 p.m., indicated the Social Services Director (SSD) and the Director of Nursing (DON) notified Resident 1's family member (FM, unspecified) that the SSD could not arrange transportation for Resident 1 on 1/6/2020 because the insurance company could only schedule transportation when requested within five business days. The note indicated FM arranged transportation for Resident 1 and would meet Resident 1 at the hospital. A review of Resident 1's Nurses Progress Note, dated 1/6/2020 at 1:14 p.m., LVN 1 indicated that Resident 1 had an appointment for a scheduled surgery on 1/6/2020 and required transportation to pick up Resident 1 at 7 a.m. LVN 1 also documented that Resident 1 was missing. LVN 1 also documented that the transportation company staff did not notify the facility staff that Resident 1 was picked up. A review of Resident 1's Social Services Progress Note, dated 1/6/2020 at 1:39 p.m., indicated the SSD called Resident 1's insurance company and informed her that there was no scheduled transportation pick-up for Resident 1. During an interview on 1/7/2020 at 4:15 p.m., the SSD stated she received a call from the GACH on 1/3/2020 to ask if transportation had been set up for Resident 1 for his scheduled surgery on 1/6/2020. The SSD stated an unspecified FM set up the transportation pick-up time on 1/6/2020 for 7:25 a.m. and would escort Resident 1 to his appointment. During a telephone interview on 3/2/2020 at 11 a.m., an Administrative Assistant 1 (AA 1) from the [MEDICAL TREATMENT] Center 1 stated the insurance company would not guarantee transportation requests if it not scheduled within at least three business days. AA 1 stated that residents of a skilled nursing facility who do not need a gurney or wheelchair, the [MEDICAL TREATMENT] Center 1 would not assist in arranging transportation rides to appointments unless it was for routine [MEDICAL TREATMENT]. AA 1 stated he received the call on 1/3/2020 from Resident 1's primary physician (MD 1) regarding Resident 1's surgery on 1/6/2020. AA 1 stated that the skilled nursing facility was responsible for informing the family about the surgery and making the necessary arrangements. During a telephone interview on 3/2/2020 at 12:50 p.m., Resident 1's FM 2 stated the facility was supposed to arrange the transportation ride for Resident 1. FM 2 stated did not make transportation arrangements. During an interview on 3/2/2020 at 1:01 p.m., Resident 1 stated he waited from 7 a.m. to 8:10 a.m. at the facility until he saw a bus across the street and made the decision to take it in an attempt to get to his scheduled surgery at the GACH on time. During an interview on 3/2/2020 at 2:28 p.m., the DON stated the SSD was responsible for arranging transportation for Resident 1. A review of the facility's policy and procedures titled, Transportation, dated 8/2012, indicated the Social Services must organize/coordinate transportation to outside appointments in conjunction with nursing services.

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F 0745 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 2)