

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENTIFICATION NUMBER <b>055617</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED <b>05/12/2020</b>
NAME OF PROVIDER OF SUPPLIER <b>PASADENA GROVE HEALTH CENTER</b>		STREET ADDRESS, CITY, STATE, ZIP <b>1470 N FAIR OAKS AVE PASADENA, CA 91103</b>	
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 0684  <b>Level of harm</b> - Minimal harm or potential for actual harm  <b>Residents Affected</b> - Few	<p><b>Provide appropriate treatment and care according to orders, resident's preferences and goals.</b></p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b></p> <p>Based on observation, interview, and record review, the facility failed to follow discharge instructions from the general acute care hospital to provide counseling therapy for depression for one of two residents (Resident 1). This deficient practice had the potential for a decline in the resident's mental status. Findings: A review of Resident 1's Admission Record indicated the resident was admitted to the facility on [DATE], with admitting [DIAGNOSES REDACTED]. A review of Resident 1's nursing notes dated 1/24/20, at 7:56 p.m., indicated Resident 1 was admitted to the facility. The following note dated 1/25/20, at 3:38 a.m. (about 7 hours after admission), indicated Resident 1 was restless and pacing up and down the hallway. At 3:09 p.m. (about 12 hours from first behavior note) had a change in condition with behavioral symptoms of agitation and [MEDICAL CONDITION]. The physician was notified and PET team (Psychiatric Emergency Teams are mobile teams operated by psychiatric hospitals approved by the Department of Mental Health to provide 5150-danger to self or others evaluations) was called. A review of Resident 1's care plan for depression dated 1/25/20, indicated psyche consult would be provided. A review of Resident 1's History and Physical dated 1/26/20, indicated Resident 1 had the capacity to understand and make decisions. A review of Resident 1's nursing notes dated 1/27/20, at 3:24 a.m., indicated Resident 1 verbalized she wanted to leave the facility and return to her home. A secondary note under the behavior note, indicated at 3:10 a.m., Resident 1 left the facility without staff knowledge. At 5:20 a.m., law enforcement called the facility and notified them that Resident 1 was found and taken to a General Acute Care Hospital (GACH). A review of Resident 1's General Acute Care Hospital (GACH) discharge information dated 1/27/20, indicated Resident 1 required follow up with Social Services for depression. The GACH's recommendations were for group or one-to-one counseling and support from family, clergy, community group or 12-step program. A review of Resident 1's nursing note dated 1/27/20, at 12:54 p.m., indicated Resident 1 was readmitted to the facility with [DIAGNOSES REDACTED]. On 1/28/20, at 2:09 p.m., during an observation and concurrent interview, Resident 1 was seen pacing the hallway with her arms over her eyes walking towards the exit doors. Resident 1 stated she was not safe because she had a bomb and was going to blow up and wanted to voluntary go to the GACH. A review of the Facility Assessment (the facility does a full assessment of the types of services they can provide to make decisions about admitting residents) dated 9/25/19, indicated each resident will be evaluated to ensure the specific care needs necessary are met. The facility assessment failed to indicate the facility provided support from community group or 12-step program as required for the resident.</p>		
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.