STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055480	A. Building B. Wing	09/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Californian Pasadena Healthcare	120 Bellefontaine Street Pasadena, CA 91105

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 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted (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 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to develop a baseline care plan within 48 hours of admission for one of three sampled residents (Resident 1), who was admitted with a peripherally inserted central catheter (PICC line - a long flexible catheter inserted through a vein in the upper arm). This deficient practice resulted in Resident 1 not receiving appropriate care, monitoring and assessment specific to her PICC line. Findings: During a review of Resident 1's admission Record, the admission Record indicated Resident 1 was admitted to the facility on [DATE] with diagnoses including obstructive hydrocephalus (when excess fluid builds up in the brain, normal pathways that drain the fluid are blocked, often by a tumor, infection), type 2 diabetes mellitus without complications (DM- a disorder characterized by difficulty in blood sugar control and poor wound healing), and malignant neoplasm of the brain (a dangerous growth of cancerous cells in the brain that invades and destroys health tissue). During a review of Resident 1's Skin Supplemental Assessment, dated 8/13/2025, the Skin Supplemental Assessment indicated Resident 1 had a right antecubital (the area of the forearm located in front of the elbow) PICC line, 5 French (Fr- unit of measurement for outer diameter of tubing), triple lumen, intact, no signs and symptoms (s/s) of infection noted, total length 41 centimeters (cm- unit of measurement for length). During a review of Resident 1's Minimum Data Set (MDS - a resident assessment tool), dated 8/19/2025, the MDS indicated Resident 1 had moderately impaired cognitive skill (problems with thinking, memory, judgement) for daily decision making. Resident 1 required substantial/maximal assistance (helper does more than half the effort) with eating and oral/personal hygiene. Resident 1 was dependent (helper does all of the effort and resident does none of the effort to complete the activity) with toileting hygiene, shower/bathe self, upper/lower body dressing, and putting on/taking off footwear. The MDS indicated Resident 1 had a central line (PICC) on admission. During a concurrent interview and record review, on 9/4/2025, at 12:14 PM, with the Director of Nursing (DON), Resident 1's medical records were reviewed. The DON stated Resident 1 had a PICC line on her right antecubital area upon admission and could not find a baseline care plan in Resident 1's medical records regarding this care area. The DON stated licensed nurses, and the Minimum Data Set Coordinator (MDSC) were responsible for creating baseline care plans for residents. During an interview, on 9/4/2025, at 1:52 PM, the MDSC stated Resident 1 should have had a baseline care plan addressing the resident's dressing changes, site monitoring for infection, and assessment for the PICC line, since Resident 1 was assessed to have the PICC line upon admission. The MDSC stated baseline care plans were created within 48 hours of a resident's admission to the facility and it was important for Resident 1 to have the baseline care plan for the PICC line to provide quality care. During a follow up interview, on 9/4/2025, at 2:58 PM, the DON stated Resident 1 should have had a baseline care plan with initial interventions and goals for PICC line 48 hours after admission. The DON stated the facility's P&P for baseline care plan was not followed. During a review of the facility's policy and procedure (P&P) titled, Care Plans- Baseline, undated, the P&P indicated a baseline plan of care to meet the resident's immediate health and safety needs was developed for each resident within forty-eight (48) hours or admission. The baseline care plan included instructions needed to provide effective, person-centered care of the resident that meet professional standards of quality care and must include the minimum healthcare information necessary to properly care for the resident.

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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 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide for the safe, appropriate administration of IV fluids for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure the peripherally inserted central catheter (PICC line- a long flexible catheter that is inserted through a vein in the upper arm) care and dressing was provided in accordance with professional standards of practice for one of three sampled residents (Resident 1). Resident 1's PICC line was not changed every seven days as indicated in the facility's policy. This deficient practice had the potential to result in Resident 1 developing an infection on the PICC line insertion site. Findings: During a review of Resident 1's admission Record, the admission Record indicated Resident 1 was admitted to the facility on [DATE] with diagnoses including obstructive hydrocephalus (when excess fluid builds up in the brain, normal pathways that drain the fluid are blocked, often by a tumor, infection), type 2 diabetes mellitus without complications (DM- a disorder characterized by difficulty in blood sugar control and poor wound healing), and malignant neoplasm of the brain (a dangerous growth of cancerous cells in the brain that invades and destroys health tissue). During a review of Resident 1's Minimum Data Set (MDS - a resident assessment tool), dated 8/19/2025, the MDS indicated Resident 1 had moderately impaired cognitive skills (problems with thinking, memory, judgement) for daily decision making. Resident 1 required substantial/maximal assistance (helper does more than half the effort) with eating and oral/personal hygiene. The MDS indicated Resident 1 had a central line (PICC) on admission. During a review of Resident 1's Skin Supplemental Assessment, dated 8/13/2025, the Skin Supplemental Assessment indicated Resident 1 had a right antecubital (the area of the forearm located in front of the elbow) PICC line, 5 French (Fr- unit of measurement for outer diameter of tubing), triple lumen, intact, no signs and symptoms (s/s) of infection noted, total length 41 centimeters (cm- unit of measurement for length). During a concurrent interview and record review, on 9/4/2025, at 12:14 PM, with the Director of Nursing (DON), Resident 1's medical records were reviewed. The DON stated it was the responsibility of the Treatment Nurse (TN) or the Registered Nurse (RN) Supervisor to change Resident 1's PICC line dressing at least every seven days. The DON stated Resident 1's PICC line should have been changed on 8/19/2025 and there was no documentation to indicate Resident 1's PICC line was changed on or before 8/19/2025. During an interview, on 9/4/2025, at 12:15 PM, with the DON and the Assistant DON (ADON), the ADON stated she changed Resident 1's PICC line but could not state the date it was changed. The ADON stated she did not document the PICC line dressing change in Resident 1's medical record. The DON stated if the PICC line change was not documented then it was considered not done. The DON stated the facility's policy for Central Venous Catheter Care was not followed. The DON stated it was important to change Resident 1's PICC line dressing to prevent complications like infections. During a review of the facility's policy and procedure (P&P) titled, Central Venous Catheter Care and Dressing Changes, undated, the P&P indicated to change the dressing if became, damp, loosened or visibly soiled and at least every 7 days. The P&P indicated that the purpose of this procedure was to prevent complications associated with intravenous (within or through a vein) therapy, including catheter-related infections that were associated with contaminated, loosened, soiled, or wet dressings.