STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056080	A. Building B. Wing	09/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Bellefontaine Healthcare Center	150 Bellefontaine St 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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review, the facility failed to maintain accurate documentation of the urine output for one (1) of 2 sampled residents (Residents 1) with indwelling catheter (a flexible tube that passes through the urethra [a tube through which the urine leaves the body] and into the bladder to drain urine) in the resident's Medication Administration Record (MAR) and urine output log in accordance with the facility's policy. This deficient practice had the potential to result in miscommunication among staff and resulted in the medical records inaccurate representation of care provided to Residents 1.Findings:During a review of Resident 1's admission Record, the admission Record indicated the resident was admitted to the facility on [DATE] with diagnosis of urinary retention (inability to completely empty the bladder). During a review of Resident 1's order summary report dated 8/13/2025, the order summary report indicated an order to record indwelling catheter output in milliliter (ml - units of volume on liquids) every shift for 30 days. 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 severe impairment in cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decision making. The MDS also indicated Resident 1 was dependent (helper does all the effort) with toileting and personal hygiene, shower, upper and lower body dressing and putting on/taking off footwear and required substantial/maximal assistance (helper does more than half the effort) with eating and oral hygiene. The MDS further indicated Resident 1 had an indwelling catheter. During a review of Resident 1's urine output task log by the Certified Nursing Assistants (CNAs) from 8/13/2025 to 8/20/2025, the urine output task log indicated the following:8/15/2025 at 10:07 PM, evening shift (3 PM - 11 PM) = no documented amount.8/16/2025 at 5:01 PM, evening shift = zero (0) urine output.8/17/2025 at 10:59 PM, evening shift = no documented amount.8/19/2025 at 10:33 PM, evening shift and 5:55 AM, night shift (11 PM - 7 AM) = no documented amount. During a review of Resident 1's MAR from 8/13/2025 to 8/20/2025, the indwelling catheter urine output log indicated the following:8/15/2025 urine output three times (x3) on evening shifts.8/16/2025 urine output of 250 cc on evening shift.8/17/2025 urine output x3 on evening shift.8/19/2025 urine output x2 on evening and night shift. During an interview on 9/8/2025 at 3:15 PM, CNA 1 stated she did not remember why she documented no amount of urine on Resident 1's urine output task log dated 8/15/2025 during the evening shift CNA 1 also stated Resident 1's urine output should be documented so that the nursing staff would know exactly how much urine output Resident 1 had and to see if the resident was drinking enough fluids. During an interview on 9/8/2025 at 3:50 PM, the Licensed Vocational Nurse 1 (LVN 1) stated CNAs should document the amount of urine in the urine output task log every time they empty Resident 1's indwelling catheter bag (a receptacle that collects urine from an indwelling urinary catheter) so that the facility would be able to identify any urinary retention, potential signs of dehydration and/or indwelling catheter blockage (a buildup of crystals from urine, blood clots, or other materials, preventing urine from flowing out of the body). During an interview on 9/9/2025 at 3:15 PM, LVN 2 stated he worked on 8/15/2025 and 8/17/2025 evening shift. LVN 2 also stated the amount of urine output should be accurately documented in the MAR which should be in ml, so that the licensed staff would know when to notify the attending physician for any concerns or issues. During a concurrent interview and record review on 9/9/2025 at 3:30 PM with CNA 1, Resident 1's urine output task log dated 8/15/2025 to 8/19/2025 and MAR dated from 8/13/2025 to 8/19/2025 were reviewed. CNA 1 stated the licensed staff log on to Resident 1's MAR was not consistent with the numbers / amount of urine output documented in Resident 1's urine output task log. CNA 1 confirmed she did not remember why she did not put an exact amount of urine emptied in Resident 1's indwelling catheter bag on 8/15/2025. During an interview on 9/9/2025 at 4:50 PM, LVN 3 stated the charge nurses (CNs- LVN who is in charge during the shift) are responsible in documenting urine output in the resident's MAR and the CNAs documents the urine output on the urine output task log. LVN 3 also stated at the end of the shift, the CNs are responsible for communicating with the CNAs how much urine output Resident 1 had. LVN 3 further stated the urine output entered in the MAR should be the total amount on that shift including the amount in the CNAs urine output task log and should be documented in ml and not how many times the resident urinated. LVN 3 also stated the amount of urine entered in the MAR and urine output task log should be accurate to know if Resident 1 had adequate urine output and to know the resident's hydration status. During an interview on 9/9/2025 at 5:13 PM, the Director of Nursing (DON) stated the CNAs should have communicated with the CNs on how much urine output Resident 1 had