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	12/08/2025

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 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. (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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(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	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** DPS:Based on observation, interview and record review, the facility failed to administer an intravenous (IV -within a vein) medication at the prescribed infusion rate for one of two sampled residents (Resident 3). This failure resulted in Resident 3's Vancomycin (Vanco- a medication used to treat infections caused by bacteria) being administered slower than prescribed, with the potential to lead to ineffective treatment or bacterial resistance for Resident 3.Findings:During a review of Resident 3's admission Record, the admission Record indicated Resident 3 was admitted to the facility on [DATE] with diagnoses that included, but not limited to, urinary tract infection (UTI- an infection in the bladder/urinary tract), gout (a painful form of arthritis [joint pain or swelling, stiffness, and tenderness] caused by too much uric acid [a waste product left over from normal chemical processes in the body] in the blood) and fracture (a crack or break in a bone) of the right femur (thigh bone) neck. During a review of Resident 3's Minimum Data Set (MDS - a federally mandated resident assessment tool) dated 11/25/2025, the MDS indicated Resident 3 had intake cognitive (ability to understand and make decisions) skills for daily decision making. The Minimum Data Set (MDS - a federally mandated resident assessment tool) also indicated Resident 3 needed substantial/maximal assistance (helper does more than half the effort) with toileting and personal hygiene, bathing, and dressing and partial/moderate assistance (helper does less than half the effort) with oral hygiene. During a review of Resident 3's Order Summary Report, dated 12/1/2025, the Order Summary Report indicated an order for Vancomycin Hydrochloric acid (HCl- is a solution of hydrogen chloride in water) intravenous solution 750 milligrams (mg-metric unit of measurement, used for medication dosage and/or amount) intravenously every 24 hours for antibiotic for methicillin-resistant staphylococcus aureus (MRSA - a bacteria that does not respond to antibiotics) related to UTI for seven (7) days. During a concurrent observation and interview on 12/8/2025 at 9:45 with Registered Nurse 1 (RN 1) at Resident 3's bedside, Resident 3's IV Vancomycin was observed with a label dated 12/4/2025 that indicated for a registered nurse to infuse Vancomycin 750 mg in 250 milliliter (ml - a metric unit for measuring volume) normal saline (NS-a saltwater solution) and infuse over 90 minutes every 24 hours for MRSA. Resident 3's Vancomycin was also observed being administered to Resident 3's IV by gravity (the method of administering IV fluids or medications where the natural force of gravity, not a pump, pushes the liquid from a raised bag down through tubing and into a resident's vein). RN 1 stated she was responsible for administering Resident 3's Vancomycin and started the administration at 9:00 AM and it should be finished at 10:30 AM. RN 1 was not able to confirm the infusion rate of Resident 3's Vancomycin infusion and stated it because she did not have the dial-a-flow infusion tubing (a medical device used to manually control the rate of IV fluids or medications delivered to a resident) at the time Resident 3's Vancomycin was started. RN 1 also stated since she cannot confirm the Vancomycin rate, she cannot ensure the infusion will be completed in 90 minutes as ordered. RN 1 stated it was important to ensure the Vancomycin is being administered at the ordered rate and time to ensure Resident 3 is receiving the proper dosage of medication and it is not given too quick or too slow. During an observation on 12/8/2025 at 11:00 AM at Resident 3's bedside, Resident 3's IV Vancomycin was observed still infusing. During an interview on 12/8/2025 at 11:48 AM with the Director of Nursing (DON), the DON stated per facility protocol, a dial-a-flow infusion set is used for IV medications including Resident 3's Vancomycin. The DON stated if it is important to give Vancomycin as ordered to prevent fluid overload (a condition where there's too much fluid in the blood) or any adverse reactions (an undesired harmful effect resulting from a medication or other intervention)to Vancomycin like shortness of breath. During an interview on 12/8/2025 at 2:00 PM with Pharmacist 1, Pharmacist 1 stated Resident 3's Vancomycin 750mg/250 ml infusion rate was calculated according to his height, weight and indication and was ordered to infuse the full 250 ml exactly in 90 minutes. During a review of the facility's policy and procedure (P&P) titled Administering an Intermittent [IV] Infusion, dated 7/2023, the P&P indicated administration procedures that included for licensed nurses are to verify physician order, medication/solution and prescribed flushing agents and to open the clamp and set rate as prescribed (via pump/rate controller as appropriate). During a review of the facility's P&P titled Administering Medications, dated 4/2019, the P&P indicated that medications are administered in a safe and timely manner, as prescribed including any required time frame.