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	05/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Bellefontaine Healthcare Center	150 Bellefontaine St Pasadena, CA 91105

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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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48395 Based on interview and record review the facility failed to follow its policy and procedure titled, Advance Directive (a written statement of a resident's wishes regarding medical treatment, often including a living will, made to ensure those wishes are carried out should the resident be unable to communicate) for two of seven (7) sampled residents (Residents 102 and 324) by not ensuring a copy of the resident's Advance Directive was readily accessible in their medical chart. This failure had the potential to cause conflict with the residents' wishes regarding health care and nursing staff not knowing if Resident 102 had specific wishes to follow in case of an emergency. Findings: 1. A review of Resident 102's Admission Record, indicated the resident was initially admitted to the facility on [DATE] with diagnoses of cerebral ischemia (acute [sudden onset] brain injury that results from impaired blood flow to the brain) and sepsis (a life-threatening condition that occurs when the body damages its own tissues and organs in response to an infection). A review of Resident 102's History and Physical Examination (H&P), dated [DATE], H&P indicated the resident has the capacity to understand and make decisions. A review of Resident 102's Minimum Data Set (MDS - a standardized resident assessment care screening tool), dated [DATE], MDS indicated the resident was moderately impaired with cognitive (ability to think, remember, and reason) skills for daily decision making, and was dependent (helper does all of the effort) with transfers (how resident moves to and from bed, chair, wheelchair, standing position), dressing (how resident puts on, fastens and takes off all items of clothing) and personal hygiene and needed substantial/maximal assistance (helper does more than half the effort) with walking and eating. A review of Resident 102's Advance Directive Acknowledgement form dated [DATE], indicated the resident had executed an Advance Directive. A review of Resident 102's Physician Orders for Life-Sustaining Treatment (POLST, a written medical order from a physician order that helps give seriously ill residents more control over their end-of-life care), dated [DATE], indicated the form was discussed with Resident 102's legally recognized decisionmaker. The POLST indicated Resident 102 had an Advance Directive. (continued on next page)

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

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident 102's clinical record (physical chart and electronic medical chart (EMR, an electronic [digital] collection of medical information about a resident that is stored on a computer), dated [DATE] to [DATE], did not indicate that there was an Advance Directive maintained in the resident's chart. During a concurrent record review of Resident 102's clinical record from [DATE]-[DATE] and interview with Registered Nurse 1 (RN 1), on [DATE] at 8:34 AM, RN 1 stated Resident 102's Advance Directive Acknowledgement form indicated the resident had executed an Advance Directive, but no Advance Directive could be found in Resident 102's clinical record. During a concurrent record review of Resident 102's clinical record from [DATE]-[DATE] and interview with Social Services Director (SSD), on [DATE] at 8:40 AM, SSD stated Resident 102's Advance Directive Acknowledgement form indicated the resident had executed an Advance Directive, but no Advance Directive could be found in Resident 102's clinical record. SSD stated that a copy of Resident 102's Advance Directive should be readily available in the chart because it allows the staff to know what the resident's wishes are in case of an emergency. During a concurrent record review of the facility's policy and procedure (P&P) titled, Advance Directive revised [DATE] and interview on [DATE] at 12:25 PM with Director of Nursing (DON), the P&P indicated, If the resident or the residents representative has executed one or more advance directive(s), or executes one upon admission, copies of these documents are obtained and maintained in the same section of the residents medical record and are readily retrievable by any facility staff. The DON stated the purpose of an Advance Directive is to make sure that a resident receives the right treatment that he/she preferred in an emergent situation. The DON also stated that a copy of a resident's Advance Directive should be readily available in the resident's medical chart so that in case of an emergency, staff will be able to access it to know the resident's wishes in regard to their health. During an interview on [DATE] at 3:50 PM, SSD stated if upon admission the resident and/or resident's representative stated they had an Advance Directive but were not able to provide it at that time, she should have followed up with them within a week to obtain a copy of the resident's Advance Directive to place it in their chart. 37662 2. A review of Resident 324's Admission Record (AR) indicated Resident 324 was admitted to the facility on [DATE] with diagnoses that included Type 2 Diabetes Mellitus (DM, a chronic condition that occurs when blood sugar levels are too high), dementia (loss of memory, language, problem-solving and other thinking abilities that are severe enough to interfere with daily life), and history of falling. A review of Resident 324's MDS, dated [DATE], indicated Resident 324 had severe impairment in cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decision making. The MDS indicated Resident 324 was dependent (helper provided all the effort or the assistance of two or more helpers was required for the resident to complete the activity) for toileting hygiene, showering/bathing, and upper body dressing, lower body dressing, and putting on/taking off footwear. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident 324's POLST dated [DATE], indicated the form was discussed with Resident 324's legally recognized decisionmaker. The POLST indicated Resident 324 had an Advance Directive (AD), dated, [DATE], and was available and was reviewed. A review of Resident 324's Advance Directive Acknowledgment, dated [DATE], indicated Resident 324 executed an AD. During a concurrent a record review of Resident 324's clinical record and interview with MDS Nurse (MDSN) on [DATE] at 10:14 AM, MDSN stated there was no AD in Resident 324's chart. MDSN stated the AD was supposed to be in Resident 324's chart. MDSN stated the facility staff has to follow what was written on the AD. MDSN stated if the AD was not in the chart, the resident will be treated as a Full Code (all medical measures will be taken to maintain and resuscitate life). MDSN stated if the resident does not want to be resuscitated (to revive from apparent death or from unconsciousness), that wish would not be valid since there was no AD in the chart. A review of the facility's policy titled, Advance Directives, revised ,d+[DATE], indicated if the resident or the resident's representative had executed one or more advance directive(s), or executed upon admission, copies of those documents were obtained and maintained in the same section of the resident's medical record and are readily retrievable by any facility staff.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. 47362 Based on observation, interview, and record review the facility failed to provide a clean comfortable, sanitary, and home like environment for one (1) of nine (9) sampled residents (Resident 47) by not ensuring that Resident 47 ' s bathroom toilet was free of fecal matter. This deficient practice caused an unsanitary environment and had a potential for Resident 27 to be placed at risk for infection injury. Findings: A review of Resident 47 ' s Admission Record indicated the facility admitted Resident 47 on 9/11/2017 with the diagnoses that included muscle weakness, abnormal posture, hypertension (when the pressure in your blood vessels is too high). A review of Resident 47 ' s Minimum Data Set (MDS, standardized care and screening tool), dated 3/30/2024, indicated Resident 47 was assessed to need substantial maximal assistance (helper does more than half the effort) on toileting, and personal hygiene. The MDS indicated Resident 47 was dependent (helper does all the effort) on toilet transfer (ability to get on and off the toilet or commode. During concurrent observation in Resident 47 ' s bathroom and interview on 5/13/2024 at 10:12 AM with License Vocational Nurse (LVN 4), LVN 4 stated the toilet seat on Resident 47 ' s bathroom has dry stool, and dark brown in color. LVN 4 further stated the toilet bowl should have been cleaned and should not have dry stool. During interview on 5/16/2024 at 8:54 AM with the Housekeeping (HSK 1), the HSK1 stated When I clean the toilet, it should be completely clean. There should not be any marks (fecal stains) left on the toilet. The HSK1 also stated, the resident, and the family would not feel good when they see the mark. Maybe they would think the toilet has not been cleaned properly. During concurrent interview and record review on 5/16/2024 at 9:24 AM with the Director of Nursing (DON), the DON stated the Policies and Procedure (P&P) titled Homelike Environment revised date February 2021, indicated the residents are provided with safe, clean, comfortable, and homelike environment. The P&P also indicated the facility staff and management maximizes, to the extent possible, the characteristics of the facility that reflect a personalized homelike setting that includes clean, sanitary, and orderly environment.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43455 Cross referenced with F656 and F758 Based on interview and record review, the facility failed to accurately complete the Minimum Data Set (MDS, a standardized assessment and care planning tool) by including a diagnosis of schizophrenia (a mental disorder characterized by disordered thinking, behaviors, and emotions that impairs daily functioning) for one of two residents sampled (Resident 119) without evidence to support this as an established diagnosis in the resident's clinical record. The deficient practice increased the risk for Resident 119 not to receive the care and treatment according to resident's needs possibly leading to a decline in overall health and well-being of the resident. Findings: A review of Resident 119's Admission Record (a document containing demographic and diagnostic information) indicated Resident 119 was admitted to the facility on [DATE] with a diagnosis including schizophrenia. A review of Resident 119's Medication Administration Record (MAR - a record of mediations administered to residents,) for May 2024, indicated Resident 119 was prescribed the following: A review of Resident 119's General Acute Community Hospital (GACH) 1 discharge records, dated 4/26/2024, indicated Resident 119 had a past medical history of atrial fibrillation (irregular heart beat), hypertension (chronic elevated blood pressure) and urinary tract infection, (condition in which bacteria invade and grow in any part the urinary system which includes the kidneys, bladder, ureters [tube that carries urine from the kidney to the urinary bladder], and urethra [canal from the bladder]) and was discharged with medications including quetiapine (an antipsychotic [against psychosis { severe mental disorder that causes abnormal thinking and perception }] medication that treats several kinds of mental health conditions including schizophrenia) 50 milligram (mg - a unit of measure of mass) one tablet by mouth at nighttime as needed for anxiety (fear characterized by behavioral disturbances), agitation and quetiapine 25 mg one tablet by mouth twice a day. A review of Resident 119's History and Physical (H&P - a record of a comprehensive physician's assessment,) by Medical Doctor 1 (MD1), dated 4/28/2024, did not indicate a confirmed diagnosis of schizophrenia. A review of Resident 119's MDS, dated [DATE], indicated resident was severely impaired with cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decision making. Resident 119 required supervision (Helper provides verbal cues) with mobility (rolling left to right), eating and oral hygiene. Resident 119 required partial/moderate assistance (Helper does less than half of the effort) with walking. Resident 119 required substantial assistance (Helper does more than half the effort) with toileting hygiene, upper body dressing, and personal hygiene. Resident 119 was dependent with shower, lower body dressing. Resident 119's diagnosis included schizophrenia. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident 119's Initial Psychiatric Evaluation by MD 2, dated 5/6/2024, did not indicate a confirmed diagnosis of schizophrenia. During an interview on 5/15/2024 at 3:31 PM, with the MDS Nurse (MDSN), the MDSC stated the facility did include a diagnosis of schizophrenia on the MDS, dated [DATE]. The MDSN stated the diagnosis was probably identified from the Quetiapine order on 4/26/2024. During a concurrent record review and interview with the Director of Nursing (DON) on 5/15/2024 at 3:46 PM, in the presence of the Assistant DON (ADON,) the DON stated the facility did include a diagnosis of schizophrenia on Resident 119's MDS assessment, dated 5/2/2024. The DON stated the GACH 1 transfer and discharge records do not indicate a diagnosis of schizophrenia and that Resident 119 was prescribed Quetiapine at GACH 1 for agitation. The DON stated that the MD 1 did not indicate a diagnosis of schizophrenia in the admission H&P of Resident 119 on 4/28/2024. The DON stated that the Medical Doctor (MD) 2 did not indicate a diagnosis of schizophrenia in for Resident 119's Initial Psychiatric Evaluation notes on 5/6/2024. The DON stated it was important for the MDS to accurately reflect the needs of the residents to ensure they maintain their highest level of functionality and quality of life. The DON stated the MDS will be immediately updated to correct the inaccurate diagnosis for Resident 119. A review of the facility's policy and procedures (P&P) titled, Resident Assessments, dated November 2019, indicated The Resident Assessment Coordinator is responsible for ensuring that the Interdisciplinary Team conducts timely and appropriate resident assessments.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37662 Based on interview and record review, the facility failed to develop and implement a comprehensive resident centered care plan for two of 23 sampled residents (Residents 103 and 119) as indicated on the facility policy and procedure by failing to ensure: 1. Resident 103 had a care plan to address Resident 103's use of Donepezil (medication used to treat dementia [a brain disorder that affects the ability to remember, think clearly, communicate, and perform daily activities]) and monitoring of cerebrovascular accidents (CVA, an interruption in the flow of blood to cells in the brain by thinning the blood) prophylaxis (PPX, action taken to prevent disease) use of plavix (medication used to prevent CVA and Deep Vein thrombosis [DVT, a condition when a blood clot forms in one or more of the deep veins in the body]) 2. Resident 119 had a care plan which included measurable goals and outcomes for monitoring atrial fibrillation (a condition with irregular, fast heart rate caused by poor blood flow), use of Eliquis (a medication used for atrial fibrillation), schizoaffective disorder (a mental condition that causes both a loss of contact with reality and mood problems), and use of Quetiapine (antipsychotic [medications used to treat mental illness]). This deficient practice had the potential for Residents 103 and 119 not to receive adequate and specific care and monitoring for their diagnoses and use of medications, which can result in untoward side effects and affect residents' overall wellbeing. Findings: 1. A review of Resident 103's Admission Record (Face Sheet), indicated Resident 103 was admitted to the facility on [DATE] with diagnoses that included Type 2 diabetes mellitus (DM - a chronic condition that occurs when blood sugar levels are too high), dementia (loss of memory and other mental abilities severe enough to interfere with daily life), and hypertension (high blood pressure). A review of Resident 103's Quarterly Minimum Data Set (MDS-a standardized assessment and care planning tool), dated 4/16/2024, indicated Resident 103 had severe impairment in cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decision making. The MDS indicated Resident 103 was dependent (helper provided all the effort or the assistance of two or more helpers was required for the resident to complete the activity) for eating, oral hygiene, toileting hygiene, showering/bathing self, and personal hygiene. A review of Resident 103's Physician Orders, dated 2/20/2024, indicated a new medication order for Donepezil hydrochloride (HCL) 10 milligram (mg, a unit of measurement) one tablet by mouth at bedtime for dementia starting on 3/4/2024. A review of Resident 103's Care Plan for cognitive loss related to dementia, initiated on 12/23/2023, indicated to administer the medication, Donepezil, as ordered. Resident 103's care plan did not indicate to monitor for side effects for Donepezil. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident 103's Medication Administration Record (MAR) for 5/1/2024 to 5/31/2024, indicated Resident 103 received Donepezil, from 5/1/2024 to 5/15/2024. Resident 103's MAR did not indicate any monitoring for side effects of Donepezil. A review of Resident 103's Physician Orders, dated 5/15/2024, indicated Plavix 75 mg one tablet by mouth once a day for CVA and DVT PPX, starting 3/4/2024. A review of Resident 103's Medication Administration Record (MAR, a record of medications administered to residents) for May 2024, indicated Resident 103 was prescribed Plavix 75 mg one tablet by mouth once a day for CVA and DVT PPX, at 9 AM. A review of Resident 103's Care Plan, initiated 10/17/2023, did not indicate a measurable goal and outcome for CVA and DVT or Plavix use. During an interview on 5/15/2024 at 3:13 PM, the Director of Nursing (DON) in the presence of the Assistant DON (ADON) stated, after a thorough search of Resident 103's clinical record, the DON was unable to locate a care plan for CVA, DVT, and use of Plavix. The DON stated there should be a care plan for CVA, DVT and Plavix to provide and monitor for an individualized plan of care for Resident 103. The DON stated without a care plan for CVA, DVT and Plavix use, the facility will not be able to see an improvement in the treatment for Resident 103. During an interview with the MDS Nurse (MDSN) on 5/16/2024 at 11:51 AM, MDSN stated MDSN would initiate a care plan for the medication, Donepezil, to monitor for any side effects of the medication. The MDSN stated there was no current care plan for Donepezil for Resident 103. The MDSN stated the medication needed its own care plan so the facility staff would be aware of what to monitor for the medication side effects. During an interview with the assistant director of nursing (ADON), on 5/16/2024 at 12:13 PM, the ADON stated Resident 103 did not have a specific care plan for the medication, Donepezil. The ADON stated the importance of having a care plan for the medication was to ensure the facility staff could monitor for possible side effects of the medication. The ADON stated if side effects were identified, facility staff would notify the Physician to prevent side effects that could cause a significant change of condition. 43455 Cross referenced with F641, F757, and F758 2. A review of Resident 119's Admission Record indicated Resident 119 was admitted to the facility on [DATE] with a diagnosis including atrial fibrillation. A review of Resident 119's MDS, dated [DATE], indicated resident was severely impaired with cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decision making. Resident 119 required supervision (Helper provides verbal cues) with mobility (rolling left to right), eating and oral hygiene. Resident 119 required partial/moderate assistance (Helper does less than half of the effort) with walking. Resident 119 required substantial assistance (Helper does more than half the effort) with toileting hygiene, upper body dressing, and personal hygiene. Resident 119 was dependent with shower, lower body dressing. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident 119's Order Summary Report, dated 5/15/2024, indicated Resident 119 was prescribed Eliquis five (5) mg to give one tablet by mouth two times a day for atrial fibrillation, starting 4/27/2024. A review of Resident 119's Medication Administration Record, for May 2024, the MAR indicated Resident 119 was prescribed: 1) Eliquis 5 mg to give one tablet by mouth two times a day for atrial fibrillation, at 9 AM and 5 PM. The MAR contained no documentation for monitoring the sign and symptoms of bleeding or bruising for Eliquis. 2) Quetiapine 50 mg to give 25 mg by mouth every 24 hours as needed for schizoaffective disorder manifested by verbal and auditory hallucinations. A review of Resident 119's Care Plan, initiated 5/2/2024, did not indicate a measurable goal for atrial fibrillation or Eliquis use, Schizoaffective Disorder or Quetiapine use. During an interview on 5/15/2024 at 12 PM, with Licensed Vocational Nurse 2 (LVN 2), LVN 2 stated Resident 119's clinical record does not include monitoring for the side effects (unwanted or dangerous medication effects) of Eliquis including bleeding and bruising. LVN 2 stated the care plan did not and should have included measurable goals for the atrial fibrillation and for the use of Eliquis to ensure Resident 119 does not potentially bleed, and that there are no subsequent atrial fibrillations as both scenarios can harm Resident 119 and cause hospitalization . During a concurrent interview, LVN 2 stated Resident 119's care plan does not have goals and outcomes for Quetiapine and Schizoaffective Disorder. During an interview on 5/15/2024 at 3:46 PM, the Director of Nursing (DON) in the presence of the Assistant DON (ADON) stated, after a thorough search of Resident 119's clinical record, the DON was unable to locate an individualized care plan for Resident 119's diagnosis of atrial fibrillation and Eliquis use, and diagnosis of schizoaffective disorder and Quetiapine use. The DON stated that monitoring for bleeding with Eliquis use was important to ensure Resident 119 does not have bleeding that was unnoticed, which may harm the resident and require hospitalization . The DON also stated not having a care plan for atrial fibrillation and schizoaffective disorder does not provide a resident centered care for Resident 119. The DON stated the facility failed to initiate a comprehensive care plan to accurately reflect the needs of Resident 119 and ensure to maintain the highest level of functionality and quality of life, with measurable goals and outcomes for atrial fibrillation, Eliquis, Schizoaffective Disorder and Quetiapine. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/15/2024 at 3:52 PM, the Pharmacy Consultant (PC) stated she was unable to locate the monitoring for the side effects of Eliquis and unable to locate a care plan for atrial fibrillation and Eliquis for Resident 119. The PC stated there should be monitoring for bleeding, bruising, and tarry (dark in color and containing blood) stools (material in a bowel movement) with Eliquis use to ensure Resident 119's treatment for atrial fibrillation does not lead to bleeding. The PC stated without adequate monitoring for the side effects of Eliquis may result in harming Resident 119 by causing bleeding that may go unnoticed. The PC stated the monitoring for side effects of Eliquis needed to start on 4/27/2024 when Eliquis was prescribed and a care plan should have been initiated at that time for the monitoring of atrial fibrillation and use of Eliquis. The PC stated not having a care plan for atrial fibrillation and Eliquis would not provide a resident-centered care which can put Resident 119's health condition at risk. A review of the facility's Policy & Procedures titled, Care Plans, Comprehensive Person Centered, dated December 2016, indicated A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident. 1. The Interdisciplinary Team (IDT), in conjunction with the resident and his/her family or legal representative, develops and implements a comprehensive, person-centered care plan for each resident. 2. The care plan interventions are derived from a thorough analysis of the information gathered as part of the comprehensive assessment. 8. The comprehensive, person-centered care plan will: a. Include measurable objectives and timeframes; b. Describe the services that are to be furnished to attain or maintain the resident's highest practicable, physical, mental, and psychosocial well-being; e. Include the resident's stated goals upon admission and desired outcomes g. Incorporate identified problem areas; h. Incorporate risk factors associated with identified problems; k. Reflect treatment foals, timetables and objectives in measurable outcomes; m. Aid in preventing or reducing decline in the resident's functional status and/or functional levels; o. Reflect on currently recognized standards of practice for problem areas and conditions. A review of the facility's P&P titled, Care Plan Comprehensive, dated 8/25/2021, indicated An individualized comprehensive care plan that includes measurable objectives and timetables to meet the resident's medical, physical, mental and psychosocial needs shall be developed for each resident. 1. Each resident's comprehensive care plan is designed to: (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	a. Incorporate identified problem areas. b. Incorporate risk and contributing factors associated with identified problems. c. Build on the resident's individualized needs, strengths, preferences. f. Reflect treatment goals, timetables, and objectives in measurable outcomes. j. Reflect currently recognized professional standards of practice for problem areas and conditions. 12. The resident's comprehensive care plan is developed within seven (7) days of the completion of the resident's comprehensive assessment (MDS).

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	05/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Bellefontaine Healthcare Center	150 Bellefontaine St Pasadena, CA 91105

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45099 Based on observation, interview, and record review, the facility failed to provide services for two (2) out of three (3) sampled residents (Residents 323 and 53) in accordance with the facility ' s policy and procedure when: 1. Facility did not inform the primary physician of Resident 323 ' s rashes on both arms and back on 5/12/2024 and was not referred to dermatology (involves the study, research, diagnosis, and management of any health conditions that may affect the skin, fat hair, nails, and membranes) for further treatment as indicated in the care plan. 2. The facility failed to inform Resident 53 ' s primary physician (MD) that Resident 53 has been refusing to elevate his right leg on a pillow and to verify with the MD if resident needs an order for Thrombo-Embolic Deterrent (TED hose, specially designed knee-high, thigh-high, or waist-high stockings that help prevent blood clots and swelling in your legs). This deficient practice had the potential to result in a delay in reducing the swelling in the affected extremities of Resident 53 and delay in treatment of Resident 232 ' s rashes and can result to physical discomfort and worsening of the skin impairment. Findings: 1. A review of Resident 323 ' s Admission Record indicated the resident was admitted to the facility on [DATE] with diagnosis of major depressive disorder (a common and serious medical illness that negatively affects how a resident feel, think and act) and adult failure to thrive (unintentional weight loss, a decline in functional abilities, and an overall decline in health status). A review of Resident 323's History and Physical (H&P), dated 1/30/2024 indicated Resident 323 does not have the capacity to understand and make decisions. A review of Resident 323 ' s Minimum Data Set (MDS, standardized assessment and care screening tool), dated 2/29/2024, indicated Resident 323 had severe impairment in cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decision making. The MDS also indicated Resident 323 was dependent (helper does all the effort) with shower and required substantial assistance (helper does more than half the effort) on toileting, upper and lower body dressing and putting on/taking off footwear. The MDS further indicated Resident 323 required supervision (helper provides verbal cues) with oral hygiene and eating. A review of Resident 323 ' s Care Plan for Skin Integrity Impairment initiated on 3/21/2024, indicated may refer to dermatology if not resolving. A review of Resident 323 ' s Treatment Administration Record (TAR) for May 2024 did not indicate a treatment was provided for Resident 323 ' s bilateral (both) arms, and back rashes prior to May 13, 2024. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent observation and interview on 5/13/2024 at 8:45 AM, Resident 323 was seen with red rashes covering both right and left anterior (front) arms. Resident 323 stated her arms were itchy including her back and neck. During an interview on 5/14/2024 at 11:55 AM, The Treatment Nurse 1 (TN 1) stated Resident 323 ' s rashes was a recurrent skin issue and had treatment order for the rashes on 3/27/24 and was discontinued last April 2024 (unable to recall exact date). During an interview on 5/15/2024 at 8:47 AM, the Certified Nursing Assistant 1 (CNA 1) stated she was the assigned CNA for Resident 323 on Sunday morning of 5/12/2024. CNA 1 stated Resident 323 told her Sunday morning on 5/12/2024 that the resident was itching, saw the rashes on the resident ' s arms and back and notified TN 2. During an interview on 5/15/2024 at 9:11 AM, TN 1 stated Resident 323 ' s rashes on both arms, back and neck area was new. TN 1 also stated CNA 1 should have also reported the skin rashes to the charge nurse, and to the Registered Nurse (RN) supervisor so that they can notify the physician and get an order if there is a need for dermatology consult. TN 1 stated, it was important to inform the physician and get a dermatology consult so that Resident 323 could get prompt treatment to prevent worsening and the development of infection. During a concurrent interview and record review of the physician ' s order dated 3/27/2024, on 5/15/2024 at 9:40 AM, the Assistant Director of Nursing (ADON) stated there was a treatment order of Clobetasol Propionate external cream (medication that reduces redness, itching, or rashes caused by skin conditions that causes dryness and itchy patches of skin) 0.05 % to be applied to general body rash topically every day and evening for eczematous dermatitis (a condition that causes the skin to become dry, itchy, and bumpy) which was started on 3/27/2024 but was discontinued on 4/9/2024. During a concurrent interview and record review of Resident 323 ' s care plan on 5/15/2024 at 9:50 AM, the ADON stated the licensed nurse should have conducted a systematic (uses a system, method, or plan) skin inspection for Resident 323 ' s on 5/12/2024 and daily during am/pm care, should have evaluated the resident ' s skin weekly and reported any skin abnormalities to the primary physician. A review of the facility ' s policy and procedure titled, Skin/Pressure Injury (localized damage to the skin and underlying soft tissue, usually occurring over a bony prominence or related to medical devices) Risk Assessment, revised March 2017, indicated its purpose was to provide guidelines for the structured assessment and identification of residents at risk for developing new pressure injuries or worsening of existing pressure injuries or other skin issues. 47362 2. A review of Resident 53's Admission Record indicated the facility admitted Resident 53 on 3/16/2020 with diagnosis which include hypertension (high blood pressure, occurs when the force of blood pushing through your vessels is consistently too high) and hyperlipidemia (there is too much cholesterol in the blood). A review of Resident 53's MDS, dated [DATE], indicated Resident 53 rarely /never understood. The MDS also indicated Resident 53 ability to walk 10 feet was not attempted (the resident did not perform this activity prior to the current illness.) (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident 53's order summary report indicated on 4/30/2024 to monitor Resident 53's right foot daily for edema (swelling caused by too much fluid trapped in the body's tissues)/ swelling. During a concurrent interview and record review on 5/15/2024 at 2:54 PM of the Resident 53's care plan with the minimum data set nurse (MDSN), the MDSN stated the resident care plan date initiated 4/30/2024 indicated focus: Skin impairment manifested by recuring chronic (continuing or occurring again and again for a long time) right foot pitting edema(occurs when excess fluid builds up in the body, causing swelling; when pressure is applied to the swollen area, a pit, or indentation, will remain). The care plan intervention indicated: bilateral (both legs) TED hose as ordered. On in AM and off in PM. The care plan also indicated elevate site (did not indicate if right leg or left leg or BLE) while on bed and on wheelchair. During the same interview with MDSN on 5/15/2024 at 2:54 PM, MDSN stated Resident 53's care plan was not person- centered because Resident 53 has been refusing to elevate his right leg on a pillow so MD should have been informed and care plan should have been revised to reflect other interventions for the right leg swelling. In addition, MDSN stated the care plan indicated bilateral TED Hose as ordered and there was no physician's order for TED Hose and resident only needs it for the right leg and not bilateral legs. MDSN stated, there was no documented evidence that MD was made aware of Resident 53's refusal to elevate his right leg on a pillow and no documented evidence the licensed nurses verified with the MD if Resident 53 needs an order for TED Hose. During observation on 5/13/2024 at 10:45 AM, observed Resident 53' laying in bed with right leg swelling and right leg was not elevated with a pillow. During concurrent observation in Resident 53's room and interview on 5/15/2024 at 4:44 PM with Registered Nurse (RN1), the RN1 stated Resident 53's right foot was not elevated on a pillow. RN1 also stated Resident 53 has right leg edema, the right leg should be elevated with a pillow. A review of facility's policy and procedure (P&P) titled Care Plan, Comprehensive Person - Centered revised date 3/3/2022 indicated A comprehensive person- centered care plan that includes measurable objective and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 37662 Based on observation, interview, and record review the facility failed to follow Physician's Orders (PO) and implement care plan (CP) interventions to provide care and services to prevent potential accidents for two of three sampled residents (Resident 68 and Resident 84) by failing to ensure: 1. Resident 68's behavior of kicking the foot board of bedframe was addressed and included an intervention on Resident 68's CP to prevent injury. 2. Resident 84's bed was in a low position. These deficient practices had the potential to affect Resident 68 and Resident 84's safety and increase the risk for injury which could result in serious harm. Findings: 1. A review of Resident 68's Admission Record (AR) indicated Resident 68 was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included dysphagia (difficulty swallowing), dementia (loss of memory, language, problem-solving and other thinking abilities that are severe enough to interfere with daily life), and gastro-esophageal reflux disease (GERD; digestive disorder that occurs when acidic stomach juices, or food and fluids back up from the stomach into the esophagus [muscular tube through which food passes from the throat to the stomach]). A review of Resident 68's Quarterly Minimum Data Set (MDS, a standardized assessment and care planning tool), dated 3/26/2024, indicated Resident 68 had severe impairment in cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decision making. The MDS indicated Resident 68 had impairment on bilateral (both sides) upper extremities (shoulder, elbow, wrist, hand) and bilateral lower extremities (hip, knee, ankle, foot). A review of Resident 68's Self Inflicted Injury CP, dated 10/26/2023, indicated Resident 68 was at risk for self-inflicted injury due to Resident 68's aggressive behavior such as but not limited to as follows: 1. Episodes of banging and/or punching Resident 68's siderails with Resident 68's arms and hands 2. Hitting Resident 68's self with Resident 68's fist, would not follow safety instructions when reminded due to Resident 68's TBI (Traumatic Brain Injury; when a sudden, external, physical assault damages the brain). 3. Banging over bed table being placed across Resident 68's wheelchair when Resident 68 was up for Resident 68's meal 4. Kicking foot board with Resident 68's both legs risk for complications and injury, 5. Episodes of yelling and aggressive yelling and screaming. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident 68's CP indicated to provide cushion such as padded side rails (adjustable metal or rigid plastic bars that attach to the bed) when in bed to minimize possible injury when Resident 68's aggressive behavior occurred. Resident 68's CP did not address any interventions for Resident 68's behavior of kicking the foot board with Resident 68's both legs. During an observation on 5/13/2024 at 2:48 PM, Resident 68 was moaning out loud, yelling, and kicking the footboard of his bed. During an observation on 5/15/2024 at 8:42 AM, Resident 68 was kicking the footboard of his bed. No padding was observed at the foot of Resident 68's bed. During a concurrent observation and interview with the assistant director of nursing (ADON) on 5/15/2024 at 2:02 PM, the ADON stated Resident 68's diagnosis of TBI could cause Resident 68's kicking behavior. The ADON stated she would call Resident 68's Physician and family member in order to place a pad at the foot board. The ADON stated since Resident 68 is kicking the bed, the padding would be to prevent injuries for Resident 68. The ADON stated she would add it to Resident 68's CP so the facility staff is aware of Resident 68's plan of care. The ADON stated the facility staff would implement the intervention and that the padding would be in place at all times to prevent injuries for Resident 68. During an interview with MDS nurse (MDSN) on 5/16/2024 at 11:35 AM, MDSN stated Resident 68's CP would be revised to avoid any type of injury due to Resident 68's behavior. 47362 2. A review of Resident 84's Admission Record indicated the facility admitted Resident 84 on 3/18/2021 with diagnoses which include muscle weakness, lack of coordination, hypertension (when the pressure in the resident ' s blood vessels is too high). A review of Resident 84's MDS, dated [DATE], indicated Resident 84 was moderately impaired with cognitive skills for daily decision making. The MDS indicated Resident 84 substantial/ maximum assistance (helper does more than half the effort. Helper lifts or hold trunks or limbs and provide more than half the effort) on toilet hygiene, shower /bathe self, personal hygiene. A review of Resident 84's Order Summary Report, dated 2/25/2024, indicated Low bed to decrease potential for injury. A review of Resident 84's Care Plan, revised 11/21/23, indicated Resident 84 was high risk for falling related to poor safety awareness, decrease strength endurance, unsteady gait, visual deficit, and history of fall. The care plan intervention included was for the facility staff to keep bed in lowest position with brakes locked. During an observation on 5/13/2024 at 10:51 AM, Resident 84's bed was high, approximately three feet above the floor. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During concurrent observation and interview and record review on 5/15/2024 at 4:38 PM, Registered Nurse 1 (RN1) stated Resident 84's bed was not in the lowest position. The RN1 also stated the Physicians order and care plan was not implemented. The RN1 further stated it was important to follow the physician's order for the safety of the resident. A review of facility's Policy and Procedure (P&P) titled, Physicians Order, revised 7/2016 indicated All orders must be specific and complete with all necessary details to carry out the prescribed order without any question. A review of facility's P&P titled, Care Plan, Comprehensive Person - Centered revised 3/3/2022, indicated A comprehensive person centered care plan that includes measurable objective and timetables to meet the resident ' s physical, psychosocial and functional needs is developed and implemented for each resident. order without any question. The comprehensive person-centered care plan would describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37662 Based on observation, interview, and record review the facility failed to follow Physician Order and implement care plan interventions to provide care and services for one (1) of four sampled residents (Resident 68) by failing to ensure: Resident 68's head of bed (HOB) was elevated to at least 30 degrees while receiving g-tube (gastrostomy tube-a tube that is placed directly into the stomach through an abdominal wall incision for administration of food, fluids, and medications) feedings. This failure had the potential for Resident 68 to be at risk for aspiration (a condition in which food, liquids, saliva, or vomit enters the airway or lungs) pneumonia which could result in harm, serious illness, or death. Findings: During a review of Resident 68's Admission Record (Face Sheet), indicated Resident 68 was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included dysphagia (difficulty swallowing), dementia (loss of memory, language, problem-solving and other thinking abilities that are severe enough to interfere with daily life), and gastro-esophageal reflux disease (GERD; digestive disorder that occurs when acidic stomach juices, or food and fluids back up from the stomach into the esophagus [muscular tube through which food passes from the throat to the stomach]). During a review of Resident 68's Quarterly Minimum Data Set (MDS, a standardized assessment and care planning tool), dated 3/26/2024, the MDS indicated Resident 68 had severe impairment in cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decision making. The MDS indicated Resident 68 had impairment on bilateral (both sides) upper extremities (shoulder, elbow, wrist, hand) and bilateral lower extremities (hip, knee, ankle, foot). During a review of Resident 68's Physician Orders, dated 2/14/2024, the Physician Order indicated to elevate HOB 30-45 degrees when g-tube feeding was on. During a review of Resident 68's Physician Order, dated 4/26/2024, the Physician Order indicated to administer Isosource 1.5 (g-tube feeding formula) at 60 millimeters (ml-a volume measurement) per hour for 20 hours. The PO indicated to turn on the g-tube feeding at 2 PM and to turn off at 10 AM or after the dose was completed. During a review of Resident 68's Enteral Feeding (food or drug administration via the human gastrointestinal [mouth, throat, esophagus, stomach, small intestine, large intestine, rectum, and anus] tract) care plan, dated 5/15/2024, the care plan indicated to elevate HOB to prevent aspiration. During an observation on 5/13/2024 at 8:04 AM, Resident 68's HOB was elevated 20-25 degrees while receiving g-tube feeding. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 5/15/2024 at 8:28 AM, Resident 68's HOB was elevated to 45 degrees, but Resident 68's head was positioned lower than Resident 68's body while receiving g-tube feeding. During an observation on 5/15/2024 at 8:41 AM, Resident 68's HOB was not elevated, and Resident 68 was lying flat in bed. During a concurrent observation and interview with licensed vocational nurse 2 (LVN 2) on 5/15/2024 at 8:52 AM, LVN 2 stated Resident 68's HOB should be at least 45 degrees whenever the g-tube feeding was on and to maintain an upright position an hour after the g-tube feeding was off. LVN 2 stated it definitely did not look like Resident 68's HOB was elevated to 45 degrees. LVN 2 stated the importance of elevating Resident 68's HOB was for aspiration precautions. During a concurrent observation and interview with assistant director of nursing (ADON) on 5/15/2024 at 9:09 AM, the ADON stated Resident 68 was not in the position Resident 68 should be in. The ADON stated Resident 68's HOB should be elevated to at least 35 to 45 degrees because of Resident 68's g-tube. The ADON stated Resident 68 was almost laying down in a flat position. The ADON stated Resident 68 was on a g-tube feeding which placed Resident 68 at risk for aspiration pneumonia. The ADON stated Resident 68 should have positioning pillows to help Resident 68 retain or maintain proper positioning. During a review of the facility's policy and procedure (P&P), titled, Enteral Feeding- Safety Precautions, revised on 11/2018, indicated to elevate the head of bed (HOB) at least 30 degrees during tube feeding and at least 1 hour after feeding to prevent aspiration.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48395 Based on observation, interview, and record review the facility failed to provide the necessary care for two (2) of 2 sampled residents (Residents 79 and 85) who are on oxygen therapy (supplemental oxygen, a treatment that provides you with extra oxygen to breath) by: 1. Facility failed to ensure Resident 79's nasal cannula (NC; a device that delivers extra oxygen through a tube and into your nose) oxygen tubing connected to their oxygen tank was stored in a bag and not sprawled out along the Resident 79 ' s wheelchair seat and touching the wheelchair wheels and failed to ensure that the resident ' s humidified (increased moisture) oxygen nasal cannula tubing was not touching the floor when in use. 2. Facility failed to ensure Resident 85's continuous positive airway pressure (CPAP, a machine that uses mild air pressure to keep breathing airways open while you sleep) has an order, and CPAP mask was stored in a bag when not in used on 5/13/2024 and 5/16/2024. This failure had the potential to result in Resident's 79 and 85 developing a respiratory infection. Findings: 1. A review of Resident 79 ' s Admission Record indicated the resident was initially admitted to the facility on [DATE] with diagnoses of encephalopathy (damage or disease that affects the brain) and type 2 diabetes (DM2, a condition that happens because of a problem in the way the body regulates and uses sugar as fuel). A review of Resident 79 ' s History and Physical Examination (H&P), dated 4/25/2024, indicated the resident does not have the capacity to understand and make decisions. A review of Resident 79 ' s Minimum Data Set (MDS, a standardized resident assessment care screening tool), dated 5/2/2024, indicated the resident was moderately impaired with cognitive (ability to think, remember, and reason) skills for daily decision making, was dependent (helper does all of the effort) with bed-to-chair transfers, dressing (how a resident puts on, fastens and takes off all items of clothing), and personal hygiene and needed setup or clean-up assistance (helper sets up or cleans up; resident completes activity) with eating. During a concurrent interview and observation on 5/13/2024 at 8:53 AM with Infection Preventionist (IP) in Resident 79 ' s room, Resident 79 ' s NC tubing was found connected to her oxygen tank on her wheelchair, spread out along her wheelchair seat with the end of the NC tubing and nose prongs touching the right wheelchair ' s wheel. IP stated the NC tubing should have been stored in a bag to prevent it from touching any surfaces such as the wheelchair ' s wheel to avoid contamination. During a concurrent interview and observation on 5/14/2024 at 7:17 AM with IP, in Resident 79 ' s room, Resident 79 ' s NC tubing connected to humidified oxygen was observed touching the floor. IP stated, the oxygen tubing should not be touching the floor to prevent contamination since it puts the resident at risk for contracting a respiratory infection. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and observation on 5/14/2024 at 9:52 AM with Licensed Vocational Nurse 3 (LVN 3) in Resident 79 ' s room, Resident 79 ' s NC connected to humidified oxygen was observed on the floor. LVN 3 stated that the NC tubing should not be touching the floor for infection control since bacteria can spread from whatever is on the floor to the resident. 46087 2. A review of Resident 85 ' s Admission Record, Admission Record indicated the resident was initially admitted to the facility on [DATE] with diagnoses of obstructive sleep apnea (occurs when the throat muscles relax and block the airway) and type 2 diabetes (DM2; a condition that happens because of a problem in the way the body regulates and uses sugar as fuel) and chronic obstructive pulmonary disease (COPD, lung diseases that block airflow and make it difficult to breathe). A review of Resident 85 ' s care plan regarding respiratory care, revised on 6/10/2022, with goal to improve airway function, indicated an approach to have Resident 85 on CPAP every hour of sleep at 20 millimeters of mercury (mmHg, unit of measurement) as ordered at bedtime (9 PM). A review of Resident 85 ' s MDS dated [DATE], MDS indicated the resident was moderately impaired with cognitive skills for daily decision making. It also indicated that Resident 85 needed setup or clean-up assistance with eating, needed supervision with oral hygiene, needed partial/moderate assistance with upper body dressing, personal hygiene and required substantial assistance with toileting hygiene, shower, lower body dressing and putting on/taking off footwear. A review of Resident 85 ' s order summary report, dated 4/30/2024, report did not indicate CPAP machine and setting order. During an observation on 5/13/2024 at 10:47 AM at Resident 85 ' s room, Resident 85 was sleeping in bed, and CPAP mask was not stored in a container or bag and was observed hanging behind the bed of Resident 85. During a concurrent interview and observation on 5/16/2024 at 12:50 PM with Licensed Vocational Nurse 3 (LVN3) in Resident 85 ' s room, Resident 85 ' s CPAP mask was not stored in a container or bag and was found on top of the bedside drawer. LVN3 stated the CPAP mask should have been stored in a bag to prevent it from touching any surfaces or worst falling to the floor and being contaminated. During a concurrent record review of Resident 85 ' s medical records and interview on 5/16/2024 at 3:30 PM with Assistant Director of Nursing (ADON), ADON stated Resident 85 did not have an active physician ' s order for CPAP machine use that includes that CPAP machine setting from 5/13/2024 to 5/16/2024. ADON also stated, CPAP mask care wherein frequency when to change the mask should be included in the physician ' s order. ADON stated, if a scheduled CPAP mask have been ordered, then having a bag where to place the CPAP mask should have been available and prevented Resident 85 ' s CPAP mask being left on top of bed side cabinet when not in use. ADON added care plan regarding CPAP use for Resident 85 should have revised to include CPAP machine and mask care. (continued on next page)

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	05/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the facility ' s policy and procedure (P&P) titled, Departmental (Respiratory Therapy) - Prevention of Infection revised November 2011, the P&P indicated, The purpose of this procedure is to guide prevention of infection associated with respiratory therapy tasks and equipment, including ventilators (a type of breathing apparatus, a class of medical technology that provides mechanical ventilation by moving breathable air into and out of the lungs, to deliver breaths to a patient who is physically unable to breathe, or breathing insufficiently), among residents and staff. The P&P also indicated to, Keep the oxygen cannula and tubing used as needed (PRN) in a plastic bag when not in use. A review of the facility ' s P&P titled, Infection Prevention and Control Program revised October 2018, the P&P indicated, An infection prevention and control program (IPCP) are established and maintained to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. A review of the facility ' s P&P titled, CPAP/BiPAP Support, revised March 2020, preparation indicated to review the Physician ' s order to determine the oxygen concentration and flow, and the Positive end-expiratory pressure (PEEP, keeps the airways and small lung spaces open to allow for adequate oxygenation when a person cannot breathe on their own) for the machine.

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	056080	A. Building B. Wing	05/16/2024

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Some	Post nurse staffing information every day. 45099 Based on observation, interview, and record review, the facility failed to ensure the Daily Posted Nurse Staffing (Nurse Staffing Information) posted was accurate in accordance with the facility's policy and procedure by failing to reflect the correct total number and actual hours of licensed and unlicensed nursing staff directly responsible for resident care. This deficient practice had the potential for the Nurse Staffing Information not to be available to the residents and visitors at any given time. Findings: During a concurrent record review of the Nurse Staffing Information, dated 5/10/2024, and interview with the Director of Staff Development (DSD) on 5/15/2024 at 3:19 PM, the DSD stated the Nurse Staffing Information indicated, eight (8) Certified Nursing Assistants (CNAs) are working for 10:30 PM to 6:30 AM shift instead of actual count of seven (7) CNAs who worked for that shift. During a concurrent record review of the Nurse Staffing Information, dated 5/11/2024, and interview with the DSD on 5/15/2024 at 3:25 PM, the DSD stated the Nurse Staffing Information indicated two (2) Restorative Nursing Assistants (RNAs) for 7 AM to 3PM shift but should have been one (1) who actually worked. The DSD also stated the number of Registered Nurse (RNs) indicated in the Nurse Staffing Information was 2 for 2:30 PM to 10:30 PM instead of one (1) and the CNA count for 10:30 PM to 6:30 AM indicated eight (8) but should have been nine (9). The DSD further stated it was his responsibility to make sure the Nurse Staffing Information was accurate. During a concurrent record review of the Nurse Staffing Information, dated 5/12/2024, and interview with the DSD on 5/15/2024 at 3:37 PM, the DSD stated the Nurse Staffing Information indicated fourteen (14) CNAs for 7 AM to 3 PM shift instead of twelve (12) who worked for that day and shift. During an observation on 5/14/2024 at 8:47 AM, the Nurse Staffing Information, located at the front lobby area indicated five (5) Licensed Vocational Nurses (LVNs) and ten (10) CNAs for 2:30 PM - 10:30 PM shift. The Nurse Staffing Information also indicated nine (9) CNAs for 10:30 PM - 6:30 AM shift. During a concurrent record review of the Nurse Staffing Information, dated 5/14/2024, and interview with the DSD on 5/15/2024 at 05:01 PM, the DSD stated the Nurse Staffing Information for 2:30 PM - 10:30 PM shift indicated 5 LVNs but actual who worked was only 4 and CNA numbers indicated 10 CNAs but actual number who worked was 9. The DSD also stated The Nurse Staffing Information also indicated nine (9) CNAs who worked for 10:30 PM - 6:30 AM shift but the actual count of CAN who worked for that shift was 10. The DSD further stated the Nurse Staffing Information should be accurate since it reflects the direct hours for nursing care. (continued on next page)

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	05/16/2024

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Some	During an interview on 5/15/2024 at 5:15 PM, DSD stated the Nurse Staffing Information was to inform the residents ' families or anyone visiting what the nursing coverage was to ensure the facility was able to provide quality nursing care. The DSD also stated an accurate Nurse Staffing Information is posted daily to let the family and visitors know how many RN, LVNs and CNAs are working that day. During an interview on 5/16/2024 at 9:11 AM, the Director of Nursing (DON) stated the DSD was assigned to do the Nurse Staffing Information and making sure it is accurate. The DON also stated the Nurse Staffing Information is there to ensure residents will receive the care they needed based on the acuity. The DON further stated the Nurse Staffing Information needs to be accurate so that the residents, residents ' families, and visitors would know if the facility had enough staff to provide care for their loved ones and for themselves. A review of the facility policy titled, Posting Direct Care Daily Staffing Numbers, revised August 2022, indicated that the facility will post daily for each shift nurse staffing data, including the number of nursing personnel responsible for providing direct care to the residents. The policy also indicated that the information recorded on the form shall include the actual number of licensed and non-licensed nursing staff working for the posted shift.

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	056080	A. Building B. Wing	05/16/2024

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 43455 Based on interview and record review, the facility failed to ensure control and accountability of Controlled Substance (CS- medications which have a potential for abuse and may also lead to physical or psychological dependence) awaiting final disposition (process of returning and/or destroying unused medications) when the facility's Narcotic and Hypnotic Record (also known as CS) accountability logs for March 2024 and May 2024 did not include the verifying signatures of either the Director of Nursing (DON) or a Registered Nurse (RN) along with the Licensed Vocational Nurse (LVN), as indicated on the facility policy and procedures. This deficient practice increased the opportunity for CS diversion (the transfer of a controlled substance or other medication from a lawful to an unlawful channel of distribution or use) and accidental exposure of residents to harmful medications, potentially negatively impacting their health and wellbeing. Findings: A record review on 5/15/2024 at 1:58 PM, with the DON, the Narcotic and Hypnotic Record accountability logs for March and May 2024 indicated the accountability logs for the CSs awaiting final disposition did not contain any verifying signatures. During an interview, the DON stated was unable to locate the verifying signatures of LVNs and the RN/DON on the accountability logs. The DON stated she failed to sign the March and May 2024 logs. The DON stated the DON counts the CSs with the LVNs upon receipt of the accountability logs, however the process of signing all logs was not consistent. The DON stated she needed to fully implement the process for including verifying signatures on the accountability logs to ensure each CS dose was accounted for until disposed. The DON stated it was also important to verify and sign the logs to prevent diversions and accidental exposure of harmful substances to residents. A review of the facility's policy and procedures (P&P) titled, Controlled Substances, dated January 2018, indicated that Medications included in the Drug Enforcement Administration (DEA) classification as controlled substances are subject to special handling, storage, disposal, and recordkeeping in the facility, in accordance with federal and state laws and regulations. A. The DON and the consultant pharmacist (CP) in collaboration maintain the facility's compliance with federal and state laws and regulations in the handling of controlled medications. E. Accurate accountability of the inventory of all controlled drugs is maintained at all times. A review of the facility's P&P titled, Controlled Medication Disposal, dated December 2022, indicated that Medications included in the Drug Enforcement Administration (DEA) classification as controlled substances are subject to special handling, storage, disposal, and recordkeeping in the facility, in accordance with federal and state laws and regulations. (continued on next page)

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	056080	A. Building B. Wing	05/16/2024

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A. The DON, in collaboration with the CP, is responsible for the facility's compliance with federal and state laws and regulations in the handling of controlled medications. B. When a dose of a controlled medication is removed from the container for administration but refused by the resident or not given for any reason, it is not placed back in the container. It is destroyed in the presence of two licensed nurses, and the disposal documented on the accountability record/book on the line representing that dose. The same process applies to the disposal of unused partial tablets and unused portions of single dose ampules and doses of CS wasted for any reason.

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	056080	A. Building B. Wing	05/16/2024

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46087 Based on interview and record review, the facility failed to address the use of Trazadone (used to treat major depressive disorder [a mood disorder that causes a persistent feeling of sadness and loss of interest], anxiety disorders [persistent and excessive worry that interferes with daily activities], and insomnia [hard to fall asleep, hard to stay asleep]) order, on the medication regimen review (MRR, or Drug Regimen Review, a thorough evaluation of the medication regimen of a resident, with the goal of promoting positive outcomes and minimizing adverse consequences and potential risks associated with medication) for one of five sampled Residents (Resident 61) in accordance with the facility policy. This deficient practice had the potential for unnecessary medication administered to Residents 61, which could result to serious harm. Findings: A review of Resident 61's Admission Record indicated an initial admission to the facility on [DATE], and readmission on 2/20/2022 with diagnoses of major depressive disorder, anxiety disorder, and delusional disorder (a type of mental health condition in which a person can't tell what's real from what's imagined. A review of Resident 61's Minimum Data Set (MDS, a standardized assessment and care planning screening tool), dated 4/1/2024, indicated Resident 61 had moderate cognitive (resident's ability to think, learn, remember, use judgement, and make decisions) skills for daily decision making. The MDS indicated Resident 61 did not have any mood symptoms. The MDS indicated Resident 61 was independent with eating and required setup or clean up assistance with oral hygiene. The MDS indicated Resident 61 required supervision (oversight, encouragement, or cueing) with putting on/taking off footwear, required partial/moderate assistance with toileting hygiene, upper body dressing, lower body dressing, and personal hygiene. The MDS indicated Resident 61 was dependent during shower. A review of Resident 61's History and Physical Examination (H&P), dated 11/15/2023, H&P indicated the resident has a past medical history of insomnia. A review of Resident 61's Order Summary Report dated 4/30/2024, indicated an order of Trazadone 50 milligrams (mg, unit of measurement) tablet, give 25 mg orally at bedtime, for depression manifested by inability to sleep, with order date of 4/9/2024. During a concurrent record review of Resident 1's Medication Administration Record for the month of April and May 2024, and interview with Pharmacist Consultant (PC) on 5/15/2024 at 4:45 PM, PC stated that Resident 61's Trazadone order for depression should have been reviewed during the April and May MRR. PC stated that this order should have been for insomnia manifested by inability to sleep, and there should be a separate order to monitor hours of sleep to check the effectiveness of the medication. PC stated that hours of sleep monitoring was not ordered, and it was not done since Resident received Trazadone on 4/9/2024 until present (5/14/2024). (continued on next page)

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	056080	A. Building B. Wing	05/16/2024

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent record review of Resident 61's Order Summary Report, dated 4/30/2024, and interview with Assistant Director of Nursing (ADON) on 5/16/2024 at 3:45 PM, the ADON stated the Trazadone order should be indicated for Resident 61's inability to sleep because she has insomnia. The ADON stated the order should have been clarified, and the licensed nurses should have monitored Resident 61's number of hours of sleep to monitor the effectiveness of Trazadone and the need for medication adjustment if necessary. A review of facility's Policy and Procedure (P&P), titled Medication Regimen Reviews, revised in May 2019, indicated the consultant pharmacist reviews the medication regimen of each resident at least monthly. It indicated that MRR involves a thorough review of the resident's medical record to prevent, identify, report, and resolve medication related problems, medication errors and other irregularities, for example: medications ordered in excessive doses or without clinical indication. medication regimens that appear inconsistent with the resident's stated preferences. inadequate monitoring for adverse consequences. Policy also indicated that an irregularity refers to the use of medication that is inconsistent with accepted pharmaceutical services standards of practice; is not supported by medical evidence; and/or impedes or interferes with achieving the intended outcomes of pharmaceutical services. It may also include the use of medication without indication, without adequate monitoring, in excessive doses, and or in the presence of adverse consequences

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	05/16/2024

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident’s drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43455 Cross referenced with 656 Based on interview and record review, the facility failed to include appropriate monitoring to ensure resident's drug regimen was free from unnecessary medications (any medication in excessive dose, excessive duration, without adequate monitoring) for one of five sampled residents (Resident 119) by failing to monitor Resident 119 for sign and symptoms of bleeding for the use of Eliquis (a medication used for atrial fibrillation [a condition with irregular, fast heart rate caused by poor blood flow,]) for 15 days. This deficient practice had the potential to cause Residents 119 to receive suboptimal (less than the highest standard or quality) care, experience serious adverse consequences (unwanted, uncomfortable, or dangerous effects that a drug may have) possibly resulting in bleeding, hospitalization , or death. Findings: A review of Resident 119's Admission Record (a document containing demographic and diagnostic information) indicated Resident 119 was admitted to the facility on [DATE] with diagnosis including atrial fibrillation. A review of Resident 119's Minimum Data Set (MDS - a comprehensive resident assessment tool), dated 5/2/2024, indicated resident was severely impaired with cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decision making. Resident 119 required supervision (Helper provides verbal cues) with mobility (rolling left to right), eating and oral hygiene. Resident 119 required partial/moderate assistance (Helper does less than half of the effort) with walking. Resident 119 required substantial assistance (Helper does more than half the effort) with toileting hygiene, upper body dressing, and personal hygiene. Resident 119 was dependent with shower, lower body dressing. A review of Resident 119's Order Summary Report, dated 5/15/2024, indicated Resident 119 was prescribed Eliquis 5 milligram (mg - a unit of measure of mass) to give one tablet by mouth two times a day for atrial fibrillation, starting 4/27/2024. A review of Resident 119's Medication Administration Record (MAR - a record of medications administered to residents), for May 2024, indicated Resident 119 was prescribed Eliquis 5 mg to give one tablet by mouth two times a day for atrial fibrillation, at 9 AM and 5 PM. The MAR contained no documentation for monitoring the sign and symptoms of bleeding or bruising for Eliquis. (continued on next page)

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	056080	A. Building B. Wing	05/16/2024

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 5/15/2024 at 12 PM, with Licensed Vocational Nurse 2 (LVN2), LVN 2 stated Resident 119's clinical record does not include monitoring for the side effects (unwanted or dangerous medication effects) of Eliquis including bleeding and bruising and does not include a care plan (a document outlining a detailed approach to care customized to an individual resident's need) with measurable goals for atrial fibrillation and for the use of Eliquis. LVN 2 stated there should be adequate monitoring for side effects and care plan for Eliquis and atrial fibrillation to ensure Resident 119 does not potentially bleed, and that there are no subsequent atrial fibrillations as both scenarios can harm Resident 119 and cause hospitalization . During an interview on 5/15/2024 at 12:25 PM, with LVN 3, LVN 3 stated residents with Eliquis use should be monitored for bleeding since that is a side effect of the medication. LVN 3 stated without an order to monitor for bleeding, bleeding can be missed and harm the resident potentially requiring hospitalization . During an interview on 5/15/2024 at 3:46 PM, with the Director of Nursing (DON) and in the presence of Assistant DON (ADON,) the DON stated after a thorough search of Resident 119's clinical record, the DON was unable to locate the monitoring for bleeding and bruising for the use of Eliquis. The DON also stated was unable to locate an individualized care plan for Resident 119's diagnosis of atrial fibrillation and use of Eliquis. The DON stated monitoring for bleeding with Eliquis use was important to ensure Resident 119 does not have bleeding that was unnoticed, which may harm the resident and require hospitalization . The DON also stated not having a care plan for atrial fibrillation does not provide resident centered care for Resident 119. The DON stated, the facility failed to include the monitoring for signs and symptoms of bleeding for Resident 119's use of Eliquis. The DON stated the facility also failed to initiate Resident 119's care plan with measurable goals and outcomes for atrial fibrillation and Eliquis. During an interview on 5/15/2024 at 3:52 PM, with the Pharmacy Consultant (PC), the PC stated was unable to locate the monitoring for the side effects of Eliquis and unable to locate a care plan for atrial fibrillation and Eliquis for Resident 119. The PC stated there should be monitoring for bleeding, bruising, and tarry (dark in color and containing blood) stools (material in a bowel movement) with Eliquis use to ensure Resident 119's treatment for atrial fibrillation does not lead to bleeding. The PC stated without adequate monitoring for the side effects of Eliquis may result in harming Resident 119 by causing bleeding that may go unnoticed. The PC stated the monitoring for side effects of Eliquis needed to start on 4/27/2024 when Eliquis was prescribed. The PC stated a care plan for the monitoring of Resident 119's diagnosis of atrial fibrillation and use of Eliquis should have been initiated on 4/27/2024. The PC added this would ensure a person-centered care and prevent putting Resident 119's health condition at risk. The PC stated that the PC failed to identify the lack of monitoring of Eliquis during the Medication Regimen Review on 5/7/2024. A review of the facility's policy and procedures (P&P) titled, Medication Regimen Review, dated May 2019, indicated: 2. Medication Regimen Reviews (MRR) are done upon admission (or as close to admission as possible) and at least monthly thereafter, or more frequently if indicated. 4. The goal of MRR is to promote positive outcomes while minimizing adverse consequences and potential risks associated with the medication. (continued on next page)

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	05/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Bellefontaine Healthcare Center	150 Bellefontaine St Pasadena, CA 91105

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	5. The MRR involves a thorough review of the resident's medical record to prevent, identify, report and resolve medication related problems, include medication errors and other irregularities, for example: d. inadequate monitoring for adverse consequences 9. An irregularity . may also include the use of medication without indication, without adequate monitoring, in excessive dose, and or in the presence of adverse consequences.

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	056080	A. Building B. Wing	05/16/2024

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43455 Based on observation, interview, and record review, the facility failed to ensure two (2) of five (5) sampled residents (Residents 119 and 61) were free from unnecessary use of psychotropic drug (any medication capable of affecting the mind, emotions, and behavior) in accordance with the facility policy and procedure by failing to ensure : 1. Resident 119 had a specific, measurable target behaviors related to the use of Quetiapine (antipsychotic [medication used to treat mental illness]) to ensure resident's drug regimen was free from unnecessary medications (any medication in excessive dose, excessive duration, without adequate monitoring). 2. Resident 61 was monitored for hours of sleep for the use of Trazadone (used to treat major depressive disorder [a mood disorder that causes a persistent feeling of sadness and loss of interest], anxiety disorders [persistent and excessive worry that interferes with daily activities], and insomnia [hard to fall asleep, hard to stay asleep]). This deficient practice had the potential to place Resident 119 and Resident 61 at risk for significant adverse consequence (unwanted, uncomfortable, or dangerous effects that a drug may have) from the use of unnecessary psychotropic drug, which could result to impairment or decline in the residents' mental, physical condition, functional, and psychosocial status. Findings: Cross reference to F641 and 656 1. A review of Resident 119's Admission Record (a document containing demographic and diagnostic information,) indicated Resident 119 was admitted to the facility on [DATE] with a diagnosis including schizophrenia (a serious mental condition involving a breakdown in the relation between thought, emotion, and behavior, leading to faulty perception, inappropriate actions and feelings, withdrawal from reality and personal relationships into fantasy and delusion [an unshakable belief in something untrue]). A review of Resident 119's Minimum Data Set (MDS - a comprehensive resident assessment tool), dated 5/2/2024, indicated resident was severely impaired with cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decision making. Resident 119 required supervision (Helper provides verbal cues) with mobility (rolling left to right), eating and oral hygiene. Resident 119 required partial/moderate assistance (Helper does less than half of the effort) with walking. Resident 119 required substantial assistance (Helper does more than half the effort) with toileting hygiene, upper body dressing, and personal hygiene. Resident 119 was dependent with shower, lower body dressing. MDS indicated Resident 119 had mood, but no behavioral symptoms. MDS indicated Resident 119 received antipsychotics on a routine basis. (continued on next page)

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	05/16/2024

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident 119's Medication Administration Record (MAR - a record of medications administered to residents), for May 2024, indicated Resident 119 was prescribed the following: Quetiapine 25 milligram (mg - a unit of measure of mass) to give one tablet by mouth two times a day for schizoaffective disorder manifested by verbal and auditory hallucinations, starting 4/28/2024 until 5/6/2024. Quetiapine 50 mg to give one tablet by mouth every 24 hours as needed for schizoaffective disorder manifested by verbal and auditory hallucinations, starting 4/28/2024 until 5/6/2024. Quetiapine 25 mg by mouth every 24 hours as needed for schizoaffective disorder manifested by verbal and auditory hallucinations, starting 5/6/2024 for 14 days. A review of the facility's pharmacy consultant (PC) Monthly Regimen Review (MRR), dated 5/7/2024, indicated Resident 119 had been on Quetiapine with target behavior of visual and auditory hallucinations. The review indicated, What kind of visual and auditory hallucinations is the resident having, please be more specific. In the column marked 'Follow-Through, a check mark was placed next to the handwritten comment done. During a concurrent record review of Resident 119's MAR and MRR and an interview on 5/15/2024 at 12:33 PM with the Director of Nursing (DON), the DON stated the check mark with the handwritten comment done under the Follow-Through column on the MRR, dated 5/7/2024, indicated the recommendation from the PC was carried out. The DON stated Resident 119's MAR, dated 5/15/2024, does not include an updated specific visual and auditory hallucination for the resident's Quetiapine order, indicating that the PC recommendation was not carried out. During an interview on 5/15/2024 at 12 PM, with Licensed Vocational Nurse 2 (LVN 2), LVN 2 stated Resident 119's Quetiapine order does not have a specific type of verbal and auditory hallucinations and that there are many different types of visual or auditory hallucinations. LVN 2 stated the physician will not be able to make an accurate assessment of Resident 119's medication therapy without having a monitoring for the specific type of auditory and visual hallucinations. During an interview on 5/15/2024 at 12:25 PM, with LVN 3, LVN 3 stated antipsychotic medications need to have specific indication for behaviors so that the specific behavior frequency can be accurately monitored. During an interview on 5/15/2024 at 3:46 PM, with the DON and in the presence of Assistant DON (ADON,) the DON stated the Quetiapine order for Resident 119 does not include a specific verbal and auditory hallucination and therefore, inaccurate assessments could be provided to Resident 119's MD. During an interview on 5/15/2024 at 3:52 PM, with the PC, the PC stated, had recommended on the MRR review, dated 5/7/2024, for the facility to specify the kind of visual and auditory hallucinations Resident 119 was having. The PC stated based on Resident 119's current MAR, the Quetiapine order was not updated for the specific kind of visual and auditory hallucinations, indicating the MRR recommendation was not carried out. The PC stated not having a specific behavior to monitor, will lead to inaccurate monitoring and inability to measure efficacy for the resident. 46087 (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. A review of Resident 61's Admission Record indicated an initial admission to the facility on [DATE], and readmission on 2/20/2022 with diagnoses of major depressive disorder, anxiety disorder, and delusional disorder (a type of mental health condition in which a resident cannot tell what is real from what is imagined. A review of Resident 61's Minimum Data Set (MDS, a standardized assessment and care planning screening tool), dated 4/1/2024, indicated Resident 61 had moderate cognitive (person's ability to think, learn, remember, use judgement, and make decisions) skills for daily decision making. The MDS indicated Resident 61 did not have any mood symptoms. The MDS indicated Resident 61 was independent with eating and required setup or clean up assistance with oral hygiene. The MDS indicated Resident 61 required supervision (oversight, encouragement, or cueing) with putting on/taking off footwear, required partial/moderate assistance with toileting hygiene, upper body dressing, lower body dressing, and personal hygiene. The MDS indicated Resident 61 was dependent during shower. A review of Resident 61's History and Physical Examination (H&P), dated 11/15/2023, H&P indicated the resident has a past medical history of insomnia. A review of Resident 61's Order Summary Report dated 4/30/2024, indicated an order of Trazadone 50 milligrams (mg, unit of measurement) tablet, give 25 mg orally at bedtime, for depression manifested by inability to sleep, with order date of 4/9/2024. During a concurrent record review of Resident 61's medication administration record for the month of April and May 2024, and interview with the Pharmacist Consultant (PC) on 5/15/2024 at 4:45 PM, the PC stated Resident 61's Trazadone order should have been indicated for insomnia manifested by inability to sleep. The PC added, monitoring hours of sleep was not and should have been ordered for Resident 61's use of Trazadone to check the effectiveness of the medication. The PC stated Resident 61 was not and should have been monitored for hours of sleep for resident's use of Trazadone since 4/9/2024 until present (5/14/2024). During a concurrent record review of Resident 61's Order Summary Report, dated 4/30/2024, and interview with Assistant Director of Nursing (ADON) on 5/16/2024 at 3:45 PM, the ADON stated the Trazadone order should be indicated for Resident 61's inability to sleep because she has an insomnia. The ADON stated the order should have been clarified, and the licensed nurses should have monitored Resident 61's number of hours of sleep to monitor the effectiveness of Trazadone and the need for medication adjustment if necessary. A review of the facility's Policies & Procedures (P&P,) titled Antipsychotic Medication Use, dated December 2016, the P&P indicated: Antipsychotic medications may be considered for residents with dementia but only after medical, physical, functional, psychological, emotional psychiatric, social and environmental causes of behavior symptoms have been identified and addressed. 1. Residents will only receive antipsychotic medications when necessary to treat specific conditions for which they are indicated and effective. 6. Diagnosis of a specific condition for which antipsychotic medications are necessary to treat will be based on a comprehensive assessment of the resident. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the facility's P&P, titled Psychotropic Medication Use, dated July 2022, the P&P indicated: Residents will not receive medications that are not clinically indicated to treat a specific condition. 3. Psychotropic medication management includes: d. adequate monitoring for efficacy 4. Residents who have not used psychotropic medications are not prescribed or given theses medications unless is determined to be necessary to treat a specific condition that is diagnosed and documented in the clinical record. 8. Consideration of the use of psychotropic medication is based on comprehensive review of the resident. This includes evaluation of the resident's signs and symptoms in order to identify underlying causes.

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. 47362 Based on observation, interview and record review, the facility failed to ensure five (5) of seven (7) cereal prepared in a bowl were accurately measured using a measuring cup. These deficient practice had the potential to result in meal dissatisfaction, decreased nutritional intake and weight loss or gain of the five residents. Findings: During an observation in the facility's kitchen on 5/14/2024 at 6:20 AM, observed Kitchen Staff (KS 1) scooping cereal on her right hand with gloves transferring it to 5 brown bowls. During interview on 5/16/2024 at 9:10 AM with KS1, KS 1 stated when we measure the cereal, it should be measured using a measuring cup and it is important to follow serving size so the resident can have proper caloric intake. KS 1 also stated the facility has some residents who must gain weight and some who must lose weight and if the facility do not follow the portion size, the residents would not gain or lose the necessary weight. During the same interview on 5/16/2024 at 9:10 AM with KS 1, KS 1 stated it was 5 residents who requested corn flakes on Tuesday, 5/14/2024. I prepared 7 portions. I was measuring with my hands for corn flakes (cereal) on Tuesday. Regular portion for the corn flakes is 3/4 of a cup. We need to use the white scoop which equals 3/4 of a cup. I should have measured the corn flakes using the measuring cup. If I measure with my hands, it is not possible to always measure out 3/4 of a cup each time. A review of facility policy titled, Portion Control, dated 2023, indicated to provide specific portion control information and to be sure portion served equal portion sizes listed on the menu. The policy also indicated, portion control equipment must be used, and a variety of portion control equipment should be available and utilized by employees portioning food.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47362 Based on observation, interview, and record review, the facility failed to follow proper food handling practices in accordance with their policy and procedure by failing to ensure: 1. Food in the kitchen were labeled with item name, date opened and expiration date. 2. Prepared food are dated correctly. 3. Various food containers are sealed properly. 4. Expired food was removed from the shelves and discarded. 5. Juice machine log was updated. These deficient practices had the potential to result in pathogen (germ) exposure to residents, which could place the residents at risk for developing foodborne illness ([food poisoning] with symptoms including upset stomach, stomach cramps, nausea, vomiting, diarrhea, and fever) and can lead to other serious medical complications and hospitalization . Findings: During concurrent observation in the facility's kitchen on [DATE] at 7:46 AM with the Dietary Supervisor (DS), the DS stated the bag of chocolate cookies was not labeled with best by date. The DS stated the milk container was dirty and was not labeled with open date and expiration date. The DS stated the precooked ham container was not sealed properly. The DS also stated the bowl of lettuce and finely chopped fruits was dated [DATE] but it was prepared on [DATE]. The DS stated their label maker machine was broken that is why it printed an incorrect date. During observation in the facility's kitchen on [DATE] at 7:52 AM with the DS, the DS stated the Ground Italian Seasoning lid was left open. The DS stated the Brand 1 (red wine vinegar) bottle on the shelves was expired since it was labeled with the date opened on [DATE] and it should have been discarded. During observation in the facility's kitchen on [DATE] at 7:55 PM with the DS, the DS stated the Juice Machine Cleaning log for the month of [DATE] was not updated. The DS further stated the last filled date was [DATE]. The DS stated the log was not signed on [DATE] to [DATE] meaning it was not cleaned on those days. During interview on [DATE] at 8:30 AM with the kitchen staff (KS 1), the KS 1 stated the kitchen should be kept clean, all milks and containers should have label of open date and expiration date. The KS 1 further stated it was important for the date to be accurate to know when the food get stale or expired. If food containers lid was not closed properly it can possibly cause cross contamination, and mold build ups that can cause stomachache or other food borne illness to residents. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During concurrent interview and record review on [DATE] at 1:59 PM with the DS, the DS stated the facility Policy and Procedure (P&P) titled Labeling and Dating of Food dated 2023, indicated all food items in the storeroom, refrigerator, and freezer needs to be labeled. Newly open food items need to be closed and labeled with open date and used by date. All prepared food needs to be covered, labeled, and dated. During the same concurrent interview and record review on [DATE] at 1:59 PM with the DS, the DS stated the facility's P&P titled Storage of Food and Supplied dated 2023 indicated foods and supplies will be stored properly and in safe manner. Dry bulk foods (flour, sugar, dry beans, food thickener, spices etc.) should be stored in seamless metal or plastic containers with tight cover, or bins which are easily sanitized. Bins/ containers are to be labeled, covered, and dated. During concurrent interview and record review on [DATE] at 2:00 PM with the DS, the DS stated the Dry goods storage guidelines dated 2023 indicated Vinegar expires in 2 years if not open, and 2 years if opened. The DS also stated based on the facility P&P all food should have open and best by dates, all containers should be closed properly, to prevent food contamination or sickness like stomachache, diarrhea. During concurrent interview and record review with on [DATE] at 2:05 PM with the DS, the DS stated the facility P&P titled Sanitation dated 2023 indicated All equipment shall be maintained as necessary and kept in working order. The maintenance department will assist Food and Nutrition Services (FNS) as necessary in maintaining equipment and in doing janitorial duties which the FNS cannot do and maintain maintenance records on all equipment. The FNS director will write the cleaning schedule in which he designates by job title and or employee who is to do the cleaning task. The DS stated based on the facility P&P kitchen equipment such as the juice machine should be kept clean and all kitchen logs needs to be filled up on the date they do the cleaning, if not documented that means it was not done.

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F 0847 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Inform resident or representatives choice to enter into binding arbitration agreement and right to refuse. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50203 Based on interview and record review, the facility failed to ensure one of three sampled residents (Resident 20) had the mental capacity (ability to understand the nature and consequences of a decision and to communicate a decision) to understand the terms of the facility's arbitration agreement (a private agreement that allows individual parties to resolve disputes rather than in a lawsuit) and failed to explain the arbitration to Resident 20's legal representative. This failure resulted in Resident 20 and his legal representative, the conservator (a judge-appointed person to act or decide for a conservatee [a person who needs help]), not understanding their rights to make informed decisions and choices about important aspects of Resident 20's health, safety, and welfare. Findings: During a review of Resident 20's Admission Record (Face Sheet), indicated the facility originally admitted Resident 20 on 9/17/2018 and readmitted on [DATE] with diagnoses that included traumatic subdural hemorrhage (bleeding inside the head where blood collected under one of the layers of tissue that protects the brain), advanced dementia (characterized by severe forgetfulness, frailty, and an increased need for help with personal care including incontinence [loss of bladder control] and reduced mobility), and bipolar disorder (a mental health condition that causes extreme mood swings that include emotional mania and depression). The Face Sheet indicated Resident 20 had a conservator as his legal representative. During a review of Resident 20's History and Physical (H&P, a comprehensive physician's note regarding the assessment of the resident's health status), dated 3/17/2023 and 4/10/2024, indicated Resident 20 does not have the capacity to understand and make decisions. During a review of Resident 20's Minimum Data Set (MDS-a standardized assessment and care screening tool), dated 3/21/2023 and 3/28/2024, indicated Resident 20's cognitive (the ability to think and process information) skills for daily decision making was severely impaired. During a review of Resident 20's Letters of Conservatorship (court evidence of a conservatorship [a court order that appoints someone to act or make decisions for a person who needs help]), filed on 3/8/2019, indicated the court finds the facts alleged in the petition are true; that Resident 20 was still gravely disabled (an impairment of the body or mind that makes it difficult for the person to do certain activities and interact with the world around them); and that Resident 20 was incompetent (lacking the skills and qualities needed for effective action) to give or withhold consent (willing, positive cooperation in an act or expression of desire in an activity). (continued on next page)

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F 0847 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 20's Arbitration Agreement dated 3/27/2023, indicated Resident 20 and his legal representative had read, understood, received a copy of the arbitration agreement, and represented they have authorized a legally binding document to execute the agreement and accept the terms on behalf of the resident. The arbitration agreement indicated that Resident 20 and a Facility Representative (Admission Assistant 1) electronically signed the agreement and there was no legal representative signature recorded. During a concurrent interview and record review on 5/15/2024 at 3:35 PM with the Admissions Director (AD), the AD stated that the arbitration agreement was signed upon admission. The AD stated that if the resident does not have the mental capacity to make decision, the resident's legal representative does have the responsibility to sign and accept the agreement's terms on behalf of the resident. The AD stated that if the resident had cognitive impairment and signed the agreement, the resident will not understand his rights under the arbitration agreement. The AD stated that Resident 20's legal representative should have signed the arbitration agreement. During a concurrent interview and record review on 5/16/2024 at 12:10 PM with the Director of Nursing (DON), The DON stated that if the resident had cognitive impairment and had a conservatorship, the conservator/legal representative had the responsibility to read, understand, and sign the arbitration agreement. The DON reviewed Resident 20's H&Ps dated 3/17/2023 and 4/10/2024, admission MDS dated [DATE], and annual comprehensive MDS dated [DATE]. The DON stated Resident 20 did not have the mental capacity to make decisions. The DON reviewed Resident 20's arbitration agreement. The DON stated that Resident 20 and a facility representative (Admission Assistant 1) signed the agreement, but there was no legal representative signature present. The DON stated Resident 20's conservator should have signed the arbitration agreement as the legal representative. The DON stated Resident 20 signing the arbitration agreement resulted in Resident 20 and conservator not informed of Resident 20's rights. During a review of the facility's undated policy and procedure (P&P) titled, Arbitration Agreement, the P&P indicated the resident or their legal representative certified that they read this Arbitration Agreement, understands this agreement, and been given a copy of this agreement and affirmatively represents the he/she is duly authorized, by virtue of the resident's consent, instructions, and/or durable power of attorney or other legally binding documents to execute this agreement and accept its terms on behalf of the Resident.

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	056080	A. Building B. Wing	05/16/2024

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep all essential equipment working safely. 48395 Based on observation, interview, and record review, the facility failed to keep one (1) of three (3) washing machines in good repair. This failure had the potential to result in the washing machine not being in a safe operable condition. Findings: During a concurrent observation and interview on 5/16/2024 at 9:05 AM with Infection Preventionist (IP) in the dirty laundry room, a washing machine on the furthest left side of the room was observed to have a large gash like hole on the top of the left panel of the washing machine. IP stated that hopefully they'll be able to fix it soon. During a concurrent observation and interview on 5/16/2024 at 1:30 PM with Maintenance Supervisor (MS) in the dirty laundry room, a washing machine on the furthest left side of the room was observed to have a large gash like hole near the top of the left side panel of the washing machine. MS stated that a tube that runs through the top side of the washing machine that contains the sanitizing chemicals had leaked at one point and caused the left side panel to erode (to slowly reduce or destroy) causing a large hole in the left panel of the washing machine. MS further stated that the washing machine should be kept in good repair and that it should be fixed. During a review of the facility's policy and procedure (P&P) titled, Maintenance Service, revised December 2009, the P&P indicated, The Maintenance Department is responsible for maintaining the buildings, grounds, and equipment in a safe and operable manner at all times, and the functions of the maintenance personnel include but are not limited to, Maintaining the building in good repair and free from hazards.

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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 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that a working call system is available in each resident's bathroom and bathing area. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37662 Based on observation, interview, and record review, the facility failed to ensure the call light (an alerting device for nurses or other nursing personnel to assist a resident when in need) was within the resident's reach (arm's length) for one (1) of 23 sampled residents (Resident 324). This deficient practice had the potential for Resident 324 not being able to call the facility's staff for help or assistance especially during an emergency. Findings: During a review of Resident 324's Admission Record (Face Sheet), indicated Resident 324 was admitted to the facility on [DATE] with diagnoses that included Type 2 diabetes mellitus (DM- a chronic condition that occurs when blood sugar levels are too high), dementia (loss of memory, language, problem-solving and other thinking abilities that are severe enough to interfere with daily life), and history of falling. During a review of Resident 324's Minimum Data Set (MDS-a standardized assessment and care planning tool), dated 5/2/2024, the MDS indicated Resident 324 had severe impairment in cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decision making. The MDS indicated Resident 324 was dependent (helper provided all the effort or the assistance of two or more helpers was required for the resident to complete the activity) for toileting hygiene, showering/bathing, and upper body dressing, lower body dressing, and putting on/taking off footwear. During a review of Resident 324's Morse Fall Risk Assessment (a rapid and simple method of assessing a patient's likelihood of falling), dated 4/27/2024, the Morse Fall Risk Assessment indicated Resident 324's Morse Fall Scoring was 55 (high risk score is 45 and higher) which indicated Resident 324 was at high risk for falls. During a review of Resident 324's At Risk for Falls Care Plan, dated 5/13/2024, the care plan indicated Resident 324's call light would be within reach. During an observation on 5/13/2024 at 10:03 AM, Resident 324 was sitting up in a wheelchair away from Resident 324's bed and in the middle of the room. Resident 324's call light was observed on Resident 324's bed. Resident 324 was trying to reach the call light but was unable to reach it. Certified Nursing Assistant (CNA) 2 had to move the call light from Resident 324's bed to the bedside table in front of Resident 324. During a concurrent interview and record review with a Licensed Vocational Nurse (LVN) 2 on 5/16/2024 at 9:49 AM, LVN 2 stated Resident 324 had history of falls, but Resident 324 has not had a fall in the facility. LVN 2 stated that Resident 324's Morse Fall Assessment score was 55 which indicated Resident 324 was at high risk for falls. During an interview with LVN 2 on 5/16/2024 at 10:14 AM, LVN 2 stated Resident 324's call light should have been within reach. LVN 2 stated Resident 324's call light could be placed on Resident 324's wheelchair or bedside table. (continued on next page)

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	05/16/2024

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 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility's policy and procedure (P&P), titled, Call System, Resident, dated 9/2022, indicated each resident is provided with a means to call staff directly for assistance from his/her bed, from toileting/bathing facilities and from the floor.