STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555213	A. Building B. Wing	02/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pasadena Care Center, LLC	1640 N. Fair Oaks Avenue Pasadena, CA 91103

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49537 Based on interview and record review, the facility (Facility 1) failed to maintain complete and accurate medical records in accordance with the accepted professional standards (a set of guidelines and expectations that define the competent level of care a healthcare professional should deliver) and practices and follow facility's Policy and Procedures (P&P) for one of one sampled resident (Resident 1) by failing to document resident-initiated discharge (when a nursing home resident or their representative gives notice that they want to leave the facility) coordination of Resident 1 to Facility 3 on 1/20/2025. This deficient practice had the potential to confuse members of the health care team and negatively impact the delivery of services. Findings: During a review of Resident 1's Admission Record, the Admission Record indicated the facility admitted Resident 1 on 11/1/2024 with diagnoses that included but not limited to atrial fibrillation (irregular heart beat that occurs when the upper chambers of the heart beat too fast and erratically), paranoid schizophrenia (type of schizophrenia characterized by delusions [or false beliefs such as persecution or grandiosity] and paranoia [feeling distrustful and suspicious of others]), suicide attempt (an act in which an individual tries to kill themselves but survives) by jumping from a high place, and fractures (a break or discontinuity in a bone) of the right femur (thigh bone), right tibia and fibula (two bones that make up the lower leg, together they connect the knee to the ankle joint), right patella (knee cap) and right foot, right and left mandible (horseshoe-shaped bone that forms the lower part of the face and supports the lower teeth), left foot, left radius (one of the two long bones in the forearm), and fractures of multiple ribs (curved, elongated bones that form part of the rib cage to help protect internal organs). (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 1's Minimum Data Set (MDS-a resident assessment tool) dated 11/14/2024, the MDS indicated that Resident 1had intact cognition and required supervision or touching assistance (Helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity) with eating. The MDS indicated Resident 1 required partial/moderate assistance (Helper does less than half the effort. Helper lifts, holds or supports trunk or limbs) with upper body dressing, personal hygiene, and from sitting to lying in bed and lying to sitting on side of the bed. The MDS also indicated Resident 1 required substantial/maximal assistance (Helper does more than half the effort. Helper lifts or holds trunk or limbs and provides more than half the effort) with oral and toileting hygiene, shower/bathing self, lower body dressing and putting on/taking off footwear and was dependent (Helper does all the effort. The MDS indicated Resident 1 does none of the effort to complete the activity or the assistance of two or more helpers is required for the resident to complete the activity) with chair/bed-to-chair transfer and tub/shower transfer. During an interview on 2/12/2025 at 1:30 PM with the Administrator (ADM- administrator of Facility 1), ADM stated Resident 1 was evacuated to Facility 2 due to the [NAME] fire on 1/8/2025. ADM stated she was informed by SSD 1 that Resident 1 was calling other skilled nursing facilities (SNFs-a place where people can receive medical care and rehabilitation after an injury or illness; also known as convalescent hospitals, nursing homes or rehabilitation centers) located around the city where Resident 1's friends are located to check if other SNFs can accept and admit the resident. ADM stated, she was also informed that Resident 1 verbalized that the resident does not want to be in Facility 2 and wanted to be placed close to her friends and outside doctors. ADM also stated on 1/20/2025, Resident 1 was discharged to Facility 3 from Facility 2 as a permanent resident of Facility 3 and not an evacuee. During an interview on 2/12/2025 at 1:50 PM with Social Services Designee 1 (SSD 1) from Facility 1, SSD 1 stated he did not know Resident 1 was discharged to Facility 3 until 1/20/2025 when Resident 1's friend picked up Resident 1's belongings. SSD 1 recalled calling Resident 1 to obtain Resident 1's consent to release the resident's belongings to Resident 1's friend and Resident 1 stated that Resident 1 did not need SSD 1's help looking for placement anymore as she had already found Facility 3. SSD 1 stated he did not document that phone conversation with Resident 1 on that date and time. SSD 1 stated, he had spoken with SSD 2 (social worker from Facility 2) on 1/22/2025 and SSD 2 informed SSD 1 that Resident 1 was discharged to Facility 3 on 1/20/2025 and Resident 1 was the one who requested to be transferred to a new facility closer to where Resident 1 lived. During a concurrent interview and record review on 2/12/2025 at 2 PM with SSD 1, Resident 1's physician order from Facility 1 dated 1/14/2025 was reviewed. The physician order indicated may transfer Resident 1 to Facility 2 due to Facility 1 evacuation. SSD 1 stated it was a late entry because the evacuation happened on 1/8/2025. During an interview on 2/12/2025 at 2:04 PM with Admissions Coordinator (AC), the AC stated she received a conference telephone call from Facility 3 DC and Resident 1 on 2/3/2025. AC stated during the call, Resident 1 verbalized she did not want to go back to Facility 1 and there was a bed for Resident 1 at Facility 4 the following week. AC stated she did not document the Resident 1's request to be transferred to Facility 4 in the resident's electronic medical chart and did not inform the Director of Nursing (DON). (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During the same interview with AC, AC stated she received another telephone call from Facility 3 DC that Facility 3 was sending Resident 1 back to Facility 1 as resident has been requesting to go back. AC stated she failed to document this telephone conversation in Resident 1's medical chart and failed to document that AC notified the Director of Nursing (DON), SSD 1 and ADM. During a concurrent interview and record review on 2/12/2025 at 2:30 PM with the ADM, the DON, SSD 1, and Director of Staff Development (DSD), the Transfer or Discharge, Resident-Initiated Policy dated April 2024, was reviewed. The Transfer or Discharge, Resident-Initiated Discharge policy indicated the policy and implementation included documentation. ADM stated, Facility 1 cannot provide documented evidence of the process of discharge of Resident 1 from Facility 1 to Facility 3. ADM stated documentation should have been done to reflect in the Resident's 1 medical record about Resident 1's wishes/preferences, referrals to other SNFs, refusal to return to Facility 1 and physician notification. ADM stated the facility policy for discharge documentation was not followed. ADM stated it was important to follow the policy and document the process of transfer and discharge of Resident 1 and all other residents to avoid confusion, delays, and for all members of the healthcare team to be aware if discharge was Resident 1's decision/preference, who were involved in the process, what was the progress of the discharge, where Resident 1 was going, and when discharge took place. During the same concurrent interview and record review, SSD 1 stated and verified he failed to document discussions with Resident 1 detailing the resident wanting to be moved to another SNF close to Resident 1's home, temple (place of worship), friends, and physician's clinics. SSD 1 stated he did not document that Resident 1 was the one looking for and calling facilities that would accept her at the area of her preference. SSD 1 stated it was necessary and important to document what was done in the resident's medical records to help coordinate Resident 1's wishes/preferences and discussions as it happened to avoid confusion and delay of services and coordinating transfers and discharges according to Resident 1's preferences. During a review of the facility's P&P titled Transfer or Discharge, Resident-Initiated, dated April 2024, the P&P indicated: 1 For resident-initiated discharges, the medical record contains: a. Documentation or evidence of the resident's or resident representative's verbal or written notice of intent to leave the facility. b. A discharge plan c. Documented discussions with the resident, or if appropriate, his/her representative, containing details of discharge planning and arrangements for post-discharge care.