

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555213	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/25/2025
NAME OF PROVIDER OR SUPPLIER Pasadena Care Center, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45099</p> <p>Based on observation, interview, and record review, the facility failed to ensure standard infection prevention control practices (a set of practices that prevent or stop the spread of infections and or diseases in the healthcare setting) were followed in accordance with the facility's Enhanced Barrier Precaution (EBP- infection control practices in nursing homes that focuses on reducing the spread of multi drug resistant organisms [MDRO - bacteria that have become resistant to certain antibiotics, and these antibiotics can no longer be used to control or kill the bacteria] by using targeted gown and gloves use during high-contact resident care activities [activities involving a lot of physical touching or close interaction with the resident, potentially increasing the risk of spreading germs or infections], rather than isolating residents) policy when:</p> <ol style="list-style-type: none"> 1. Certified Nurse Assistant 1 (CNA 1) did not wear an isolation gown while changing the diaper on one (1) of two (2) sampled residents on EBP (Resident 1). 2. Isolation gowns were unavailable for three (3) of five (5) sampled rooms (Rooms A, B, and C) requiring EBPs. <p>These deficient practices had the potential for cross contamination (the physical movement or transfer of harmful bacteria from one person, object, or place to another) and spread infection to residents, staff, and visitors in the facility.</p> <p>Findings:</p> <p>During a review of Resident 1's Admission Record, the Admission Record indicated the resident was initially admitted to the facility on [DATE] and readmitted on [DATE], with diagnosis including but not limit to, stroke that affected right side, diabetes (DM-body unable to use insulin correctly and sugar builds up high in the blood), hypertension (high blood pressure), and intestinal malabsorption (problems with the body's ability to absorb nutrients from food).</p> <p>(continued on next page)</p>

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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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a review of Resident 1's Minimum Data Set (MDS- a resident assessment tool), dated 2/21/2025, the MDS indicated Resident 1 had severe impairment in cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decision making. The MDS also indicated Resident 1 was dependent (helper does all the effort) with eating, oral, toileting and personal hygiene, shower, upper and lower body dressing and putting on/taking off footwear. The MDS further indicated Resident 1 had a Percutaneous Endoscopic Gastrostomy (PEG - a feeding tube placed directly into the stomach through the abdominal wall, used for patients who cannot eat or drink adequately orally) while a resident in the facility.</p> <p>During an observation on 3/25/2025 at 2 PM, an EBP sign was posted outside of Room A. Certified Nursing assistant 1 (CNA 1) changed Resident 1's soiled diaper without wearing an isolation gown.</p> <p>During an interview on 3/25/2025 at 2:25 PM, CNA 1 stated he should have used an isolation gown to protect him and the residents from contracting infections.</p> <p>During a concurrent observation and interview on 3/25/2025 at 2:12 PM, there were no isolation gowns on the gown holder attached to the right side of the wall inside Room A and confirmed by the DSD and Licensed Vocational Nurse 1 (LVN 1). LVN 1 stated Resident 1 and her 2 roommates were on EBP.</p> <p>During a concurrent observation and interview on 3/25/2025 at 2:27 PM, CNA 2 confirmed the isolation gown holder inside Room B (an EBP room) was missing isolation gowns. CNA 2 also stated isolation gowns should be worn when providing care to the resident to prevent cross contamination to other residents and to herself.</p> <p>During an interview on 3/25/25 at 2:33 PM, LVN 1 confirmed there was no isolation gown inside Room C. LVN 1 also stated Room A, B, and C are all EBP rooms and isolation gowns should be available on those rooms for the staff to use when providing care to the residents to prevent the spread of infections from resident to resident. LVN 1 further stated the staff should have easy access of Personal Protective Equipment (PPE - clothing and equipment that is worn or used to provide protection against hazardous substances and/or environments) to use for EBP rooms.</p> <p>During an interview on 3/25/2025 at 2:48 PM, the Infection Prevention Nurse (IPN) stated CNA 1 should have worn an isolation gown while doing high contact activity with Resident 1. The IPN also stated EBP residents are more susceptible to contracting infections and wearing isolation gown could help prevent the spread of infection.</p> <p>During a review of the facility's policy and procedure titled, Enhanced Barrier Precautions, revised February 2025, indicated that EBP's are utilized to prevent the spread of MDRO to residents. The policy also indicated some of the examples of high contact resident care activities requiring the use of gown and gloves for EBPs included providing hygiene and changing briefs or assisting with toileting.</p>		