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 06/14/2024
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)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48152 Based on observation, interview and record review, facility failed to treat one of three sampled residents (Resident 8) dignity and respect by failing to secure the privacy curtain during resident care as indicated in facility's policy and procedure (P&P). This failure resulted in the violation of Resident 8's rights, with the potential for Resident 8 to experience negative feelings (including disrespect). Findings: A review of Resident 8's Admission Record indicated Resident 8 was readmitted to the facility on [DATE], with diagnoses that included fracture (a break) of left humerus (upper arm bone), major depressive disorder (MDD - a mental health disorder characterized by persistently depressed mood or loss of interest in activities, causing significant impairment in daily life), chronic pain syndrome, and contracture (a condition of shortening and hardening of muscles, tendons, or other tissue, often leading to deformity and rigidity of joints). A review of Resident 8's Minimum Data Set (MDS - a standardized resident assessment care screening tool), dated 5/19/2024, indicated Resident 8 has severely impaired (difficulty with or unable to) cognitive (ability make decisions, learn, remember things) skills for daily decision making. Resident 8 was dependent (resident does none of the effort to complete activity) with toileting, bathing, and dressing. The MDS also indicated Resident 8 was always incontinent (lacking control of bowel and/or bladder). A review of Resident 8's History & Physical (H&P), dated 5/13/2023, indicated Resident 8 does not have the capacity to understand and make decisions. During an observation on 6/11/24 at 10:26 AM at Resident 8's bedside, Certified Nurse Assistant 1 (CNA1) was observed assisting Resident 8 with incontinent brief (a type of disposable underwear that allows the wearer to urinate or defecate without using a toilet) care. Resident 8's privacy curtain was observed pulled to cover only half of the curtain track, exposing Resident 8's private areas during care. (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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 6/11/2024 at 10:34 AM with CNA 1, CNA 1 stated he assisted Resident 8 and was unable to provide full privacy due to Resident 8's privacy curtain being a partial curtain, meaning it will only close halfway. CNA 1 stated there should be a full curtain for Resident 8 to protect, provide dignity and safety while providing care. During an interview on 6/11/2024 at 12:04 PM with the Director of Nursing (DON), the DON stated facility policy is to provide privacy when assisting residents with care like changing the briefs. The DON stated staff need to make sure the curtain is closed completely for privacy and to maintain the dignity of the residents. The DON also stated, If care is given and privacy is not given, like the curtain not closed, the resident will feel their privacy is invaded, they are not being respected and their rights are not being met. A review of facility's P&P titled, Incontinent Care, revised 7/2012, indicated facility will provide residents provide privacy by closing door and securing privacy curtain. A review of facility P&P titled Resident's Rights & Dignity, revised 12/2014, indicated facility will ensure the resident's rights/dignity are strictly complied (to obey a particular rule) with and that privacy will be strictly complied with during care.

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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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46087 Based on observation, interview, and record review, the facility failed to ensure the call light device (a device used by a resident to signal his or her need for assistance) was within reach for one of 23 sampled residents (Resident 56) who had a history of cerebrovascular accident (CVA, stroke- loss of blood flow to a part of the brain) and left-side hemiparesis (weakness or the inability to move on one side of the body), in accordance with the facility policy. This deficient practice had the potential to result in delayed provision of care and services for Resident 56. Findings: A review of Resident 56's Admission Record indicated Resident 56 was admitted on [DATE] with diagnoses that included occlusion and stenosis of right carotid artery (condition that happens when the large artery on either side of the neck becomes blocked), anxiety disorder (persistent and excessive worry that interferes with daily activities), and major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest) and essential hypertension (high blood pressure). A review of Resident 56's History and Physical, dated 5/28/2024, indicated Resident 56 had a diagnosis of CVA with left-side hemiparesis. A review of Resident 56's Minimum Data Set (MDS, a comprehensive assessment and care-screening tool), dated 3/22/2024, indicated Resident 56 was moderately impaired with cognitive skills (ability to think, understand, and reason) for daily decision making. The MDS indicated Resident 56 required partial assistance (helper does less than half the effort) with eating. It also indicated that Resident 56 required substantial assistance (helper does more than half the effort) with oral hygiene, upper body dressing and personal hygiene. Resident 61 was dependent to staff with toileting hygiene, shower, lower body dressing and putting on/taking off footwear. A review of Resident 56's Care Plan indicated resident is at risk for further decline in activities in daily living (ADLs) related to cerebral infarction (stroke, refers to damage to tissues in the brain due to a loss of oxygen to the area), initiated on 12/8/2023, and revised on 1/12/2024, indicated a goal that Resident 56 will have less episodes of further decline in ADLs. The Care Plan indicated a staff intervention to keep call light within easy reach and answer promptly. During a concurrent observation in Resident 56's room and interview with Resident 56 on 6/13/2024, at 9:35 AM, Resident 56 was heard screaming for help and was sitting on his wheelchair next to his bed. Resident 56's call light string was observed away from the resident, on top of the empty bed next to his bed. Resident 56 stated he could not reach his call light, so he needed to scream to ask for staff assistance to get him out of his room. Resident added, That call light should have been near me, and not placed on that empty bed. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent observation in Resident 56's room and interview with Certified Nursing Assistant 2 (CNA 2) on 6/13/2024, at 3:35 PM, CNA 2 confirmed that the call light on the wall in between Resident 56's bed and the empty bed belongs to Resident 56 and should have not place to the empty bed. CNA 2 stated, It is important for Resident to be able to reach his call light so he can call for help especially during an emergency. CNA 2 stated it is important to ask Resident 56 where he prefers his call light to be placed because he is unable to move his left arm. During an interview with Registered Nurse 1 (RN 1) on 6/14/2024 at 2:15 PM, RN 1 stated, The call light needs to be within the resident's reach always so the resident can call for assistance. A review of the facility's Policy and Procedure (P&P) titled, Accommodation of Needs, revised on 4/24/2024, indicated, .facility's environment and staff behaviors are directed toward assisting the Resident in maintaining and/or achieving safe independent functioning, dignity, and well-being. The P&P also indicated, The resident's individual needs and preferences are accommodated the extent possible, except when the health and safety of the individual or other residents would be endangered.

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46919 Based on interview and record review, the facility failed to provide reasonable accommodation to meet the choices of two of two sampled residents (Resident 37 and Resident 38) by failing to assign female Certified Nursing Assistants (CNA) as per the residents' request. This deficient practice had the potential to affect Resident 37 and Resident 38's quality of life and negatively impact their psychosocial well-being. Findings: 1. A review of Resident 37's Admission Record indicated Resident 37 was initially admitted to the facility on [DATE] and was readmitted on [DATE] with diagnoses that included benign lipomatous neoplasm (a non-cancerous lump that forms due to an overgrowth of fat cells), type 2 diabetes mellitus (a disease that occurs when the blood sugar is too high), and hemiplegia (paralysis on one side of the body) and hemiparesis (weakness or the inability to move one side of the body) following unspecified cerebrovascular disease affecting left non-dominant side (a group of disorders that affect the blood vessels and blood supply to the brain). A review of Resident 37's History and Physical Examination (H&P), dated 6/23/2023, indicated Resident 37 had the capacity to understand and make decisions. A review of Resident 37's Minimum Data Set (MDS, a standardized assessment and care planning tool), dated 4/10/2024, indicated Resident 37 had intact memory and cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decision making and was dependent (helper does all of the effort, resident does none of the effort to complete the activity) with toileting hygiene, shower/bathe self, upper body dressing, lower body dressing, and personal hygiene. A review of the facility's, Nursing Staffing Assignment and Sign-In Sheet dated from 6/1/2024 to 6/11/2024, indicated Resident 37 was assigned a male CNA on the following days and shifts: 6/1/2024 7AM - 3PM and 3PM - 11PM shift 6/2/2024 7AM - 3PM and 3PM - 11PM shift 6/3/2024 3PM - 11PM shift 6/4/2024 7AM - 3PM and 3PM - 11PM shift 6/5/2024 7AM - 3PM and 3PM - 11PM shift 6/6/2024 7AM - 3PM and 11PM - 7AM shift 6/7/2024 7AM - 3PM shift (continued on next page)

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	6/8/2024 7AM - 3PM and 3PM - 11PM shift 6/9/2024 7AM - 3PM and 3PM - 11PM shift 6/10/2024 7AM - 3PM and 3PM - 11PM shift 6/11/2024 7AM - 3PM and 3PM - 11PM shift During an interview with Resident 37, on 6/11/2024, at 10:04 AM, Resident 37 stated she has asked facility staff numerous times to assign her a female CNA to assist her with her diaper change but she keeps getting male CNAs assigned to take care of her. Resident 37 stated her husband has also informed facility staff regarding Resident 37's preference to have female CNAs assigned to her. Resident 37 stated she did not like male CNAs because they do not clean her as well as the female CNAs. Resident 37 stated she was assigned to a male CNA today. Resident 37 stated facility staff does not listen to her request. During an interview with Restorative Nurse Assistant 1 (RNA 1), on 6/12/2024, at 4:44 PM, RNA 1 stated Resident 37 informed her numerous times that she preferred female CNAs over male CNAs because female CNAs can clean Resident 37's private area better. RNA 1 stated Resident 37 also informed the day shift Charge Nurses (CN) and the previous Director of Nursing (DON) that the resident preferred a female CNA to take care of her. RNA 1 stated female residents prefer female CNAs because they feel embarrassed being seen naked by male CNAs. RNA 1 stated the request of the female residents to be assigned to a female CNA should be followed especially if the female residents are uncomfortable having a male CNA assigned to them. RNA 1 stated Resident 37 has informed her that Resident 37 felt like no one was listening to her requests. RNA 1 stated the residents needs and preferences should be heard. During an interview with CNA 3, on 6/13/2024, at 9:23 AM, CNA 3 stated since Resident 37 was admitted to the facility, the resident requested from that the resident preferred a female CNA because the resident felt more comfortable with them. CNA 3 stated facility staff were aware that Resident 37 preferred female CNAs. CNA 3 stated it was important for female residents to be assigned to female CNAs for their safety and privacy. CNA 3 stated alert and oriented female residents do not want to be seen by male CNAs. CNA 3 stated Resident 37's right and preference to have a female CNA should have been followed. During an interview with Licensed Vocational Nurse 1 (LVN 1), on 6/13/2024, at 2:52 PM, LVN 1 stated he was aware that Resident 37 has been requesting for female CNAs to take care of the resident. LVN 3 stated residents have a right to ask for a female CNA. LVN 1 stated the request and preferences of the residents should be considered and honored. LVN 1 stated there are some female residents who feel uncomfortable being seen by male CNAs. During an interview with the Director of Staffing Development (DSD), on 6/13/2024, at 3:30 PM, DSD stated residents have the right to request to be assigned to a female CNA. DSD stated resident requests should be honored. DSD also stated the facility was the residents' home and the residents should be comfortable in their home. The DSD stated female residents should also be assigned to female CNAs for their dignity and privacy. (continued on next page)

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. A review of Resident 38's Admission Record indicated Resident 38 was initially admitted to the facility on [DATE] and was readmitted on [DATE] with diagnoses that included obesity (a disorder that involves having too much body fat which increases the risk of health problems), schizoaffective disorder bipolar type (a mental health problem where a person experiences loss of contact with reality as well as episodes of extreme highs and severe lows), and muscle weakness. A review of Resident 38's MDS, dated [DATE], indicated Resident 38 had moderately impaired cognitive skills for daily decision making and required substantial/maximal assistance (helper does more than half the effort) with toileting hygiene, shower/bathe self, and lower body dressing. A review of the facility's, Nursing Staffing Assignment and Sign-In Sheet, indicated Resident 38 was assigned a male CNA on the following days: 6/1/2024 7AM - 3PM and 3PM - 11PM shift 6/2/2024 7AM - 3PM and 3PM - 11PM shift 6/3/2024 3PM - 11PM shift 6/4/2024 7AM - 3PM and 3PM - 11PM shift 6/5/2024 3PM - 11PM shift 6/6/2024 7AM - 3PM, 3PM - 11PM and 11PM - 7AM shift 6/7/2024 7AM - 3PM shift 6/8/2024 7AM - 3PM and 3PM - 11PM shift 6/9/2024 7AM - 3PM and 3PM - 11PM shift 6/10/2024 7AM - 3PM and 3PM - 11PM shift 6/11/2024 3PM - 11PM shift 6/12/2024 7AM - 3PM and 3PM - 11PM shift 6/13/2024 7AM - 3PM shift During an interview with Resident 38, on 6/13/2024, at 1PM, Resident 38 stated she felt uncomfortable every time she had a male CNA assist her with bathing and diaper change. Resident 38 stated she informed facility staff that she preferred a female CNA to help her shower and with personal hygiene. Resident 38 stated she continuous to get assigned male CNAs even after she informed facility staff she preferred female CNAs. (continued on next page)

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview with Registered Nurse 1 (RN 1), on 6/14/2024, at 3:58 PM, RN 1 stated it was important for residents to be able to choose the gender of their CNAs. RN 1 stated it was important for the dignity of a female resident to be assigned to a female CNA. RN 1 stated residents' requests should be honored as much as possible. RN 1 stated residents can feel unheard if their request was not honored. A review of the facility's policy and procedure (P&P), titled, Accommodation of Needs, revised on 4/24/2024, indicated the facility's environment and staff behaviors are directed toward assisting the resident in maintaining and/or achieving safe independent functioning, dignity, and well-being. The P&P indicated, The resident's individual needs and preferences are accommodated to the extent possible, except when the health and safety of the individual or other residents would be endangered.

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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** 48152 Based on interview and record review, the facility failed to ensure residents' medical records were updated to show documentation that advance directives (legal written instructions of a person's wishes regarding medical treatment made to ensure those wishes are carried out should the person be unable to communicate them to a doctor) were discussed and written information were provided to the residents and/or responsible parties (RP) for three of the seven sampled residents (Resident 5, 47 and 43). This deficient practice violated the Residents 5, 47 and 43 and/or the representatives' right to be fully informed of the option to formulate their advance directives and had the potential to cause conflict with the residents' wishes regarding health care. Findings: 1. A review of Resident 5's Admission Record indicated Resident 5 was readmitted to the facility on [DATE], under full code status (full life saving support which includes cardiopulmonary resuscitation (CPR), if there is no heartbeat or breathing), with diagnoses that included pneumonitis (inflammation in your lungs that can affect how well you breathe and cause other bodily symptoms, epilepsy (a disorder in which nerve cell activity in the brain is disturbed, causing seizures), Chronic Obstructive Pulmonary Disease (COPD - a lung disease that blocks airflow and make it difficult to breathe), and malignant neoplasm (cancer cells) of kidney. A review of Resident 's Minimum Data Set (MDS - a standardized resident assessment care screening tool), dated [DATE], indicated Resident 5 is rarely/never able to express needs or understand others and has a severely impaired ability to make decisions regarding daily life. The MDS also indicated Resident 5 is dependent (staff does all effort needed to complete activity) with toileting, bathing, dressing and oral hygiene, while maximal assistance (staff does more than half the effort) with eating and personal hygiene. During a concurrent interview on [DATE] at 9:59 AM with Social Services Director (SSD), Resident 5's electronic medical chart dated from [DATE] to [DATE] was reviewed. The electronic chart failed to indicate Resident 5 and/or Resident 5's RP were provided written information regarding the resident`s right to formulate an advance directive. SSD stated there is no documentation in Resident 5's chart that indicated information was given regarding advance directives to Resident 5, or the RP and it should have been in the resident's medical chart. SSD stated when information is given regarding the advance directive, it is documented in the medical record and the importance of informing residents of an advance directive is in case any [emergency] situations do happen, the facility would know the process the resident wanted and can follow it. 46919 (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. A review of Resident 37's Admission Record indicated Resident 37 was initially admitted to the facility on [DATE] and was readmitted on [DATE] with diagnoses that included benign lipomatous neoplasm (a non-cancerous lump that forms due to an overgrowth of fat cells), type 2 diabetes mellitus (a disease that occurs when the blood sugar is too high), and hemiplegia (paralysis on one side of the body) and hemiparesis (weakness or the inability to move one side of the body) following unspecified cerebrovascular disease affecting left non-dominant side (a group of disorders that affect the blood vessels and blood supply to the brain). A review of Resident 37's History and Physical Examination (H&P), dated [DATE], indicated Resident 37 had the capacity to understand and make decisions. A review of Resident 37's Minimum Data Set (MDS, a standardized assessment and care planning tool), dated [DATE], indicated Resident 37 had intact memory and cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decision making and was dependent (helper does all of the effort, resident does none of the effort to complete the activity) with toileting hygiene, shower/bathe self, upper body dressing, lower body dressing, and personal hygiene. During a concurrent interview and record review with Social Services Director (SSD), on [DATE], at 12:02 PM, Resident 37's Advance Directive Acknowledgement form dated [DATE] was reviewed. SSD stated the Advance Directive Acknowledgement form, dated [DATE], indicated Resident 37 had executed an Advance Directive. SSD stated the facility was not able to obtain a copy of Resident 37's Advance Directive from the resident's husband. SSD stated a copy of Resident 37's Advance Directive should be in Resident 37's chart to know what Resident 37's plans and decisions are regarding the resident's medical treatment. SSD stated it is important to have a copy of Resident 37's Advance Directive for the facility to know who to contact if a decision needs to be made regarding Resident 37's medical treatment. SSD stated no follow up was done to obtain a copy of the Advance Directive. 3. A review of Resident 43's Admission Record indicated Resident 43 was initially admitted to the facility on [DATE] and was readmitted on [DATE] with diagnoses that included hemiplegia and hemiparesis following cerebral infarction affecting left-non dominant side (when the blood supply to part of the brain is blocked or reduced causing muscle weakness or partial paralysis on the left side of the body), chronic obstructive pulmonary disease with acute exacerbation (COPD- a lung disease characterized by long term poor airflow), and type 2 diabetes mellitus. A review of Resident 43's MDS, dated [DATE], indicated Resident 43 had severely impaired cognitive skills for daily decision making and was dependent with toileting hygiene, shower/bathe self, lower body dressing, and toilet transfer. During a concurrent interview and record review with SSD, on [DATE], at 8:38 AM, Resident 43's chart was reviewed dated from [DATE] to [DATE]. SSD stated Resident 43 did not have an Advance Directive Acknowledgement form in the chart. SSD stated residents must sign the Advance Directive Acknowledgement form upon admission to indicate that they were provided by the facility with information regarding Advance Directives. SSD stated the Advance Directive Acknowledgement form was important to indicate if the resident was interested or not interested in obtaining an Advance Directive or if the resident had an Advanced Directive. SSD stated it was the SSD's responsibility to make sure Resident 43's chart had a signed copy of the Advance Directive Acknowledgement form. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with Registered Nurse 1 (RN 1), on [DATE], at 4:12 PM, RN 1 stated the Advance Directive Acknowledgement form needs to be completed and signed by the resident or the responsible party. RN 1 stated the Advance Directive Acknowledgement form is important because it provides the facility with information regarding the resident's Advance Directive or if the resident need assistance or information on how to write an Advance Directive. RN 1 stated Resident 43's Advance Directive Acknowledgement form should have been in Resident 43's chart. A review of the facility's policy and procedure (P&P), titled, Advance Directive Policy and Procedure, dated 2017, indicated, The resident has the right and the facility will assist the resident to formulate an advance directive at their option. The facility will inform and provide resident with a written description of the facility's policy to implement advance directives. The P&P also indicated upon admission, facility will identify if the resident has an advance directive and if not, determine if the resident wishes to formulate an advance directive and SSD or facility designee will provide residents with a written description of the facility's policy to implement advance directives and All advance directive document copies will be obtained and located in the hardcopy chart behind the face sheet, in the business office file, and/or uploaded in the Electronic Medical Record (EMR) under 'other.'

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44636 Based on interview and record review, the facility failed to provide a safe and homelike environment (having qualities associated with home; comfortable, familiar, cozy) for two (2) of 23 sampled resident (Resident 31 and 64) by: 1. Facility failed to provide protection of Resident 64's personal property from theft or loss, when Resident 64's responsible party (RP) reported missing personal belongings. 2. Facility failed to provide a bathroom to Resident 31 that did not have four missing tiles on the wall. These deficient practices resulted in the violation of the Resident 64 and 31's right of having a safe and clean environment and had the potential to cause emotional distress to the resident. Findings: 1. A review of Resident 64's Admission Record indicated Resident 64 was admitted to the facility 5/7/2024, with diagnoses of malignant (cancerous) neoplasm (abnormal growth of cells in the body) of unspecified part of unspecified bronchus (one of the two tubes that carry air into the lungs from the trachea) or lung, pleural effusion (fluid buildup in the space between the lung and the chest wall), and atelectasis (collapse of a lung or part of a lung due to air loss in the air sacs). A review of Resident 64's Minimum Data Set (MDS, a standardized assessment and care planning tool), dated 5/20/2024, indicated Resident 64's cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decision making were moderately impaired. The MDS indicated Resident 64 was dependent (helper does all of the effort, resident does none of the effort to complete the activity) for sit to stand and chair/bed-to-chair transfer. The MDS indicated Resident 64 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) for toilet hygiene, shower/bathe self, roll left and right, sit to lying, and lying to sitting on side of bed. A review of Resident 64's Care Plan, initiated 5/7/2024, indicated Resident 64 was at risk for communication problem secondary to language barrier. Staff interventions were to use resident's preferred language - Language 1 , encourage family participation, and ask simple questions requiring a yes or no answer. A review of Resident 64's Discharge Instructions Document Valuables and Belongings from the General Acute Care Hospital (GACH), dated 5/7/2024, indicated Resident 64 was discharged and had the following items: - Coat/Jacket, Pajamas, Pants, Shoes, Slippers, Socks - Cell phone, charger (continued on next page)

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 06/14/2024

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

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- Purse/wallet - Glasses, dentures lower, dentures upper. A review of Resident 64's Resident Belongings List, dated 5/7/2024, indicated Certified Nursing Assistant 4's (CNA 4) name on the signature of facility representative and the following items: - Three pairs of socks - Two reading eyeglasses - One pants color black - One sweater color light blue - Top and lower dentures - One phone charger - One iPhone cell phone - One pair of shoes The Resident Belongings List did not have the signature of the Resident/Responsible Party, Resident's name, and other facility representative's signature. The Resident Belongings List did not have a reason the resident was unable to sign. The form indicated if the resident is unable to sign, to state reason. A review of Resident 64's Social Service Assessment, dated 5/10/2024, indicated Resident 64's family member 1 (FM 1) was her RP. A review of the Complaint and Grievance Report Form (claim by a resident or resident's representative regarding dissatisfaction of the service provided and/ or reports of loss or theft), dated 5/21/2024, indicated Resident 64's RP stated a black purse with miscellaneous cards and passport went missing upon admission. Complainant informed of decision and corrective action and response was due to not being in inventory, facility was not able to reimburse lost item. The form did not have the signature and date for the Grievance Official and Administrator. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 6/12/2024 at 12:10 PM with FM 1, FM 1 stated FM 1 attended a meeting at the facility on 5/14/2024. FM 1 stated she went to Resident 64's room to look for her purse and wallet since the facility requested for Resident 64's documents. FM 1 stated Resident 64 was missing her purse and wallet. FM 1 stated Resident 64 had her social security, three (2) medical insurance card and residency identification card in the resident's wallet. FM 1 stated the missing cards were very important and difficult to obtain replacement cards once lost. FM 1 stated she had spent $450 dollars to replace Resident 64's residency identification card. FM 1 stated she was Resident 64's RP and the facility staff never went over the inventory items on the Resident Belongings List (inventory form/list) for Resident 64. FM 1 stated she requested Resident 64's inventory list once she found Resident 64's belongings were lost on 5/14/2024. FM 1 stated she had asked several nurses (unable to recall names) for the inventory list but had never received a copy of Resident 64's Resident Belongings List. During the same interview on 6/12/2024 at 12:10 PM with FM 1, FM 1 stated she went to the GACH to talk with the GACH nurse. FM 1 stated the GACH nurse showed her Resident 64's list of belongings when discharged from GACH on 5/7/2024. FM 1 stated the GACH record indicated Resident 64 still had her purse and wallet before she was sent to the facility on [DATE]. FM 1 stated on 5/21/2024 the Social Service Director (SSD) said he would text her Resident 64's inventory list. FM 1 stated she had not received a copy of Resident 64's inventory list. During an interview on 6/12/2024 at 4:50 PM with CNA 5, CNA 5 stated resident's inventory list (resident belongings list) were completed upon admission. CNA 5 stated the facility staff entered the resident's personal belongings on the form, signed, and had the resident or responsible party sign the resident belongings list form to verify the items. During an interview on 6/12/2024 at 5:27 PM with Treatment Nurse/Registered Nurse (TN/RN), TN/RN stated two nurses should sign the resident belongings list when the resident or resident's RP was not able to sign. The TN/RN stated the resident belongings list could also be signed by the CNA and the resident or the RP. TN/RN stated if the resident or responsible party was not able to sign, then two nurses should verify the resident's items and sign the resident belongings list. TN/RN stated this ensured resident inventory items were accurate and confirmed valuable items. During an interview on 6/12/2024 at 5:46 PM with CNA 4, CNA 4 stated CNA4 completed the inventory list for Resident 64 when admitted to the facility on [DATE]. CNA 4 stated Resident 64 stated that the resident was not able to sign the inventory list. CNA 4 stated Resident 64's RP was not present when the inventory list was completed on 5/7/2024. CNA 4 stated CNA 4 informed TN/RN Resident 64 did not sign the inventory list and gave TN/RN the resident belongings list. CNA 4 stated TN/RN did not verify Resident 64's belongings with CNA 4. CNA 4 stated two nurses should sign the resident belongings list to provide evidence that all the resident's belongings were checked and written down. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 6/13/2024 at 10:04 AM with RN 2, RN 2 stated the CNA would complete the resident belongings list and the alert resident would sign the form for verification when admitted . RN 2 stated the licensed nurse would also co-sign the resident belongings list to verify the resident's items were present upon admission. RN 2 stated there could be missing items not documented on the resident belongings list if only the CNA signed the inventory form. RN 2 stated the importance to have a resident belongings list verified by the resident, RP, or licensed nurse was in case the resident or RP reported a lost item. RN 2 stated when a resident or RP reported a lost item, the resident belongings list was the first document reviewed to determine if they had the item or not. RN 2 stated a grievance form would be completed and submitted to the SSD to follow up with the lost item(s). During an interview on 6/13/2024 at 10:41 AM with the SSD, SSD stated when a resident was admitted to the facility the CNA was accountable to inform the charge nurse and the RN supervisor when a resident was not able to sign the resident belongings list. SSD stated the CNA, charge nurse, and RN supervisor would sign the resident belongings list to confirm that the resident's items have all been inventoried. SSD stated the three staff signatures confirmed the resident's belongings list had been completed at the time of admission. SSD stated SSD was responsible to reviewing the resident belongings list when a resident was admitted within 24 hours or on Monday if a resident was admitted during the weekend. SSD stated when a resident or family member reported a missing item, an investigation needed to be conducted. SSD stated SSD kept track of missing items in the theft and loss folder. SSD stated the reported missing items in the theft and loss folder would be given to the Administrator (ADM) to validate. During a concurrent record review and interview of the Theft and Loss Report on 6/13/2024 at 11:00 AM with SSD, SSD stated there was nothing in the theft and lost report for this year (2024). SSD stated there was a grievance on 5/21/2024 for Resident 64. SSD stated Resident 64's responsible party informed SSD of a missing black purse. SSD stated he spoke with CNA 4 and reviewed the resident belongings list. SSD stated there was no black purse in Resident 64's resident belongings list. SSD stated he notified the responsible party on 5/21/2024 and stated the responsible party could not be reimbursed since the facility's policy indicated the purse was not on the resident belongings list. SSD stated when a resident or RP requested for a copy of the Resident Belongings List, a copy should be provided to the RP within the day. During a concurrent record review and interview of Resident 64's Resident Belongings List on 6/13/2024 at 11:11 AM with SSD, SSD stated the resident belongings list did not have the resident's signature and the charge nurse and RN supervisor did not sign the resident belongings list. SSD stated Resident 64 had a RP when Resident 64 was initially admitted to the facility on [DATE]. SSD stated Resident 64's resident belongings list was only signed by one staff, CNA 4, on 5/7/2024. SSD stated he had not followed up on Resident 64's resident belongings list since admission on 5/7/2024. SSD stated he could not confirm that all Resident 64's personal items were fully accounted for on Resident 64's Resident Belongings List since there was only one staff who signed. SSD also stated the grievance form was supposed to be turned in, reevaluated, and signed by the Grievance Official and ADM within 24 to 48 hours after 5/21/2024. SSD stated he had not turned in the grievance form to the Grievance Official and ADM. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 6/14/2024 at 3:46 PM with the Director of Nursing (DON), the DON stated when the Resident 64 was admitted , there should be two nurses to verify the Resident Belongings List since Resident 64 came from hospice (a program that gives special care to residents who are near the end of life and have stopped treatment to cure or control their disease) and was not alert and oriented. The DON stated the CNA needed to inform the charge nurse and have the charge nurse go inside Resident 64's room to verify the inventory written down in the resident belongings list. The DON stated the day after Resident 64's admission, 5/8/2024, the SSD should review the resident belongings list. The DON stated when the Resident Belongings List was not verified by two nurses, then items may become lost, not properly marked, or not properly addressed on the list. The DON stated the reported missing items also needed to be included in the theft and lost report so staff could follow up with the missing item(s). The DON stated Resident 64's grievance form was given to the SSD and when the SSD was unable to find the items, the SSD needed to inform the ADM and the DON. The DON stated the ADM and DON would ensure the grievance was thoroughly investigated, try to resolve the problem, and ensure proper communication done with the family member. A record review of the facility's policy and procedure titled, Personal Property, revised 7/2012, indicated completed inventory (resident belongings list) form will be signed by both facility staff and resident or resident representative . A record review of the facility's policy and procedure titled, Theft and Loss, revised 7/2012, indicated the facility will make every effort to find property which has been reported as lost or stolen. A theft and loss record report will be made out by the supervisor to whom the theft or loss of property of a patient, visitor, employee, or facility is reported and whose estimated value is $25.00 or more and if requested. The Administrator/SSD will investigate the situation to determine whether the report item can be found. The Theft and Loss Record report is to be forwarded to the SSD/Administrator immediately for follow-up investigation and actions. The Administrator/SSD will retain the Theft and Loss Record reports for a 12-month period. A record review of the facility's policy and procedure titled, Grievances, revised 12/2014, indicated the Grievance/Complaint Report is to be immediately forwarded to the Administration after completion. The Administrator is responsible to thoroughly investigate, assure resolution of the grievance/complaint and complete documentation of the facility's actions. 46919 2. A review of Resident 31's Admission Record indicated Resident 31 was admitted to the facility on [DATE] with diagnoses that included type 2 diabetes mellitus with hyperglycemia (a disease that occurs when the blood sugar is too high), essential hypertension (HTN-high blood pressure), and difficulty in walking. A review of Resident 31's History and Physical Examination (H&P), dated 9/30/2023, indicated Resident 31 had the capacity to understand and make decisions. A review of Resident 31's Minimum Data Set (MDS- a standardized assessment and planning tool), dated 5/4/2024, indicated Resident 31 had intact memory and cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decision making and required supervision or touching assistance with eating, oral hygiene, toileting hygiene, shower/bathe self, upper and lower body dressing, personal hygiene, and toilet transfer. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During on observation of Resident 31's bathroom, on 6/11/2024, at 10:17 AM, Resident 31's bathroom was observed to have four white tiles missing on the wall located at the right side of the toilet bowl. During an interview with Resident 31, on 6/11/2024, at 3:15 PM, Resident 31 stated the bathroom did not look nice because it had four missing tiles on the wall located at the right side of the toilet bowl. Resident 31 stated the tiles had been missing for a while and unable to recall for how long. Resident 31 stated it would be nice if the facility replaced the missing tiles. Resident 31 stated the bathroom would feel like home if it was replaced. During an interview with the Infection Preventionist Nurse (IPN 1), on 6/12/2024, at 5:40 PM, IPN 1 stated the tiles in Resident 31's bathroom should have been replaced once it was discovered missing. IPN 1 stated the missing tiles in Resident 31's bathroom made the bathroom look like it was falling apart and not homelike. IPN 1 stated it is the responsibility of all facility staff to document what rooms need to be repaired in the Maintenance log. During an interview with the Maintenance Supervisor (MS 1), on 6/13/2024, at 9:41 AM, MS 1 stated it would only take 10-15 minutes to replace the missing tiles in Resident 31's bathroom. MS 1 stated residents would not feel comfortable using a bathroom that had tiles missing on the wall. MS 1 stated the facility bathrooms should always be in good condition to maintain the resident's dignity and respect. MS 1 stated facility staff should immediately report rooms that need repair to the Maintenance Department. MS 1 stated the Maintenance Department needs to fix what is broken as soon as possible. MS 1 stated the facility should make the residents feel like they are home. During an interview with Registered Nurse 1 (RN 1), on 6/14/2024, at 3:38 PM, RN 1 stated it is important for residents to have a nice room and bathroom so they will feel good about themselves. RN 1 stated having a room and bathroom that is not homelike can make the residents sad. RN 1 stated it is the responsibility of the Maintenance Department to replace the tiles in Resident 31's bathroom. RN 1 stated the facility staff should have reported the missing tiles in Resident 31's bathroom to the Maintenance Department as soon as it was discovered missing. A review of the facility's policy and procedure (P&P), titled, Accommodation of Needs, revised on 4/24/2024, indicated the facility's environment and staff behaviors are directed toward assisting the resident in maintaining and/or achieving safe independent functioning, dignity, and well-being. A review of the facility's P&P, titled, Maintenance Service, revised on 4/2024, indicated, Maintenance service shall be provided to all areas of the building, grounds, and equipment. The P&P indicated Functions of maintenance personnel include but are not limited to providing routinely scheduled maintenance service to all areas.

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44636 Based on interview and record review, the facility failed to ensure the preadmission screening and annual resident review assessment (PASARR, preventing individuals with mental illness, developmental disability, intellectual disability, or related conditions from being inappropriately placed in nursing homes for long term care) form was accurately completed for a resident who had a mental illness for one of four sampled residents (Resident 52). This deficient practice led Resident 52 to not receive the necessary and appropriate psychiatric level of treatment and evaluation in the facility. Findings: A review of the Resident 52's Admission Record indicated Resident 52 was admitted to the facility on [DATE], with diagnoses of schizoaffective disorder (a mental illness that causes loss of contact with reality) bipolar type (mental disorder characterized by episodes of mania [extreme highs] and depression [extreme lows]), and anxiety disorder (persistent and excessive worry that interferes with daily activities). A review of the Minimum Data Set (MDS, an assessment and care screening tool), dated 6/6/2024, indicated Resident 52's cognitive (mental action or process of acquiring knowledge and understanding) patterns were intact. The MDS indicated Resident 52 had an impairment in the upper extremity (shoulder, elbow, wrist, hand) and an impairment in the lower extremity (hip, knee, ankle, foot). The MDS indicated Resident 52 was dependent (helper does all of the effort, resident does none of the effort to complete the activity) for toileting hygiene, shower/bathe self, upper and lower body dressing, roll left and right, sit to lying, lying to sitting, chair/bed-to-chair transfer, and tub/shower transfer. The MDS also indicated Resident 52 had a psychiatric (relating to mental illness or its treatment)/mood disorder and an anxiety disorder. A review of Resident 52's Physician Order Summary Report, dated 5/24/2024, indicated the following orders: - Buspirone hydrochloric acid (buspirone HCl, medication used to treat anxiety) oral tablet 5 milligram (mg, unit of measurement): Give one table by mouth two times a day for anxiety manifested by (m/b) poor impulse control. - Divalproex sodium (medication used to treat bipolar disorder) oral tablet delayed release 500 mg: Give one tablet by mouth two times a day for schizoaffective disorder bipolar type m/b mood swings. A review of Resident 52's Care Plan, dated 5/24/2024, indicated Resident 52 was on psychotropic medications for psychosis (a mental disorder characterized by a disconnection from reality), schizophrenia bipolar disorder as manifested by mood swings. The care plan indicated staff interventions included were to give divalproex medication as ordered, monitor behavior of mood swings every shift, and monitor adverse side effects of meds every shift. (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident 52's Care Plan, dated 5/24/2024, indicated Resident 52 exhibited signs and symptoms of anxiety as manifested by poor impulse control. The care plan indicated staff interventions included were to monitor behavior of poor impulse control every shift, encourage to verbalize and express feelings and concerns, and administer medications as physician ordered. A review of Resident 52's PASARR Level I Screening, dated 5/24/2024, indicated the PASARR Level I was negative (there was no suspected mental illness or intellectual/developmental disability or related condition). The PASARR Level I Screening also indicated under Section three Resident 52 did not have a serious diagnosis of mental disorder such as depressive disorder, anxiety disorder, panic disorder, schizophrenia (a chronic and severe mental disorder that affects how a person thinks, feels, and behaves)/schizoaffective disorder, or symptoms of psychosis, delusions (believed to be true or real but is actually false or unreal), and/or mood disturbance. In addition, it indicated Resident 52 was not prescribed psychotropic medications (drug or other substance that affects how the brain works and causes changes in mood, awareness, thoughts, feelings, or behavior) for mental illness. During a concurrent interview and record review of Resident 52's PASARR Level I Screening dated 5/24/2024, on 6/13/2024 at 9:55 AM with Registered Nurse 2 (RN 2), RN 2 stated Resident 52's PASARR was completed when Resident 52 was admitted to the facility on [DATE]. RN 2 stated Resident 52's PASARR indicated the resident was negative for the Level I Screening. RN 2 stated section three of the PASARR indicated Resident 52 had no mental disorder and no psychotropic medications for mental illness. RN 2 stated Resident 52's PASARR Level I Screening was incorrectly completed since Resident 52 had a diagnosis of schizophrenia and the resident was prescribed psychotropic medications (buspirone HCL and divalproex sodium). During a concurrent interview and record review of Resident 52's PASARR Level I Screening dated 5/24/2024, on 6/13/2024 at 2:46 PM with Minimum Data Set Nurse (MDSN), MDSN stated she completed Resident 52's PASARR Level I Screening on 5/24/2024. MDSN stated she was informed Resident 52 was on hospice (a program that gives special care to residents who are near the end of life and have stopped treatment to cure or control their disease), therefore she did not check Resident 52's medical records and completed the resident's PASARR incorrectly. MDSN stated she indicated in Resident 52's PASARR Level I Screening that Resident 52 did not have a serious mental illness but Resident 52 had a diagnosis of schizophrenia and anxiety upon admission. MDSN also stated she indicated in Resident 52's PASARR Level I Screening that Resident 52 was not prescribed psychotropic medications for his mental illness but Resident 52 was prescribed and was administered psychotropic medications upon admission. MDSN stated the PASARR screening should be accurately completed and was required to ensure correct placement of residents in the facility. A review of the facility's policy and procedure titled, Preadmission Screening and Annual Resident Review (PASARR), undated, indicated the PASARR process consists of the completion of a Level I screen per State and Federal requirements as well as the review and implementation of the Level II recommendations upon admission into the facility. The PASARR process requires that all applicants be given assessment to determine whether they might have a serious mental illness. Those individuals who test positive at Level I are then evaluated in depth, called Level II PASARR. The results of this evaluation result in a determination of need, determination of appropriate setting, and a set of recommendations for services to inform the individual's plan of care.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 48152 Based on interview and record review, facility failed to develop care plans (a document that outlines the facility's plan to provide personalized care to a resident that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs) for three of four residents (Resident 21, 32, and 52) per facility policy, facility failed to: 1. Develop a care plan for Resident 21 after having 4 incidents of falling. 2. Develop a care plan for Resident 32's compromised oral condition. 3. Resident 52 did not have an individualized care plan for limited range of motion on the resident's left side of body. These failures resulted in Residents 21, 3, and 52 receiving care that was not comprehensive and personalized to meet the specific needs identified above, with the potential to result in decreased quality of care and quality of life for Residents 21,32 and 52. Findings: 1. A review of Resident 21's Admission Record indicated Resident 21 was readmitted into the facility on [DATE] with diagnoses that included cellulitis (a bacterial infection of your skin and the tissue beneath your skin) of the right and lower legs, gastro esophageal reflux disease (GERD - chronic digestive disease where the contents of the stomach refluxes and irritates the esophagus), morbid obesity (condition of being severely overweight), and depression (mood disorder that causes a persistent feeling of sadness and loss of interest in life). A review of Resident 21's History & Physical (H&P), dated 8/1/2023, indicated Resident 21 has the capacity to understand and make decisions. A review of Resident 21's Minimum Data Set (MDS - a standardized resident assessment care screening tool), dated 5/16/2024, indicated Resident 21 with an intact ability to think, reason, and remember and supervision or touching assistance (staff provides verbal cues and/or touching/steadying/contact guard assistance) with eating, toileting, dressing, oral and personal hygiene, standing and transfers. The MDS also indicated Resident 21 is maximal assistance (staff does more than half the effort) with walking 10 feet. A review of Resident 21's Fall Investigation Forms, indicated Resident 21 had falls in the facility on 4/9/2024, 5/21/2024 and 6/8/2024. A review of Resident 21's Fall Risk Assessments, dated 6/8/2024, 5/24/2024, 5/21/2024, and 4/9/2024, indicated Resident 21 as a high risk for falls. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of Resident 21's Risk for Fall/Recurrent Fall Care Plan, dated 8/18/2023, failed to indicate and provide interventions for Resident 21's fall incidents on 6/8/2024, 5/24/2024, 5/21/2024, and 4/9/2024. During a concurrent interview and record review on 6/14/2024 at 10:56 AM with Licensed Vocation Nurse (LVN) 1, Resident 1's comprehensive (complete) care plan was reviewed. The comprehensive care plan failed to indicate a care plan was created for Resident 21's falls on 6/8/2024, 5/24/2024, 5/21/2024, and 4/9/2024. LVN 1 stated there were no care plans created for these falls, but should have been because per facility's protocol, a care plan is to be created every time a resident has a fall. LVN 1 stated Resident 21 is ambulatory and independent (no assistance) with walking but has had a lot of falls in the facility with the most recent being last week (6/8/2024); and Resident 21 needed a new care plan because each fall is different so the interventions should have been different. LVN 1 also stated care plans are interventions and set goals for patients and Resident 21 having 4 falls without an updated care plan, it could negatively affect his progress of healing, increase the chance of having another fall and negatively affect the resident's safety. 2. A review of Resident 32's Admission Record indicated Resident 32 was readmitted to the facility on [DATE], with diagnoses that included seizures (a sudden disruption of the brain's normal electrical activity accompanied by altered consciousness and/or other neurological and behavioral manifestations), hemiplegia (paralysis of one side of the body) and hemiparesis (inability to move one side of the body) and cerebral infarction (also known as a stroke; refers to damage to the tissues in the brain due to a loss of oxygen to the area). A review of Resident 32's MDS, dated [DATE], indicated Resident 32 is rarely/never able to express needs or understand others and is dependent (staff does all effort needed to complete activity) with toileting, bathing, dressing, oral and personal hygiene. The MDS also indicated Resident 32 has a feeding tube (a medical device used to provide nutrition to people who cannot obtain nutrition by mouth, are unable to swallow safely, or need nutritional supplementation). A review of Resident 32's H&P, dated 4/18/2024, indicated Resident 32 with a changing capacity to understand and make decisions. During a review of Resident 32's Dental Progress Notes, dated 7/20/2023, indicated Resident 32 has 16 missing teeth, heavy calculus (a hard, calcified deposit that forms and coats the teeth and gums, that can cause gum disease) on all remaining teeth, cavities (a hole in a tooth that develops from tooth decay) and incisal (surface of a tooth) wear bone loss. During a concurrent record review and interview on 6/13/2024 at 3:50 PM with Registered Nurse 3 (RN 3), Resident 32's comprehensive care plan was reviewed. The comprehensive care plan failed to indicate a care plan was created for Resident 32's oral status including conditions of missing teeth, cavities, or tooth calculus. RN 3 stated there is no care plan for Resident 32's oral health or oral care to be given and there should have been one created. RN 3 stated it is important for Resident 32 to have a care plan for her oral health because being NPO (nothing by mouth,) causes her mouth to be dry which increases her risk of tooth decay. RN 3 also stated the purpose of care plans is for residents to receive consistent care from staff, and to ensure care is given and does not put the resident at risk for new symptoms. (continued on next page)

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

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of facility's policy and procedure (P&P) titled Care Plans Comprehensive Person- Centered, revised 4/24/2024, indicated the comprehensive, person-centered care plan: a. includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident. b. describes the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being, care plans are revised as information about the residents and the residents' conditions change. c. care plans are revised as information about the residents and the residents' conditions change. 44636 3. A review of the Resident 52's Admission Record indicated Resident 52 was admitted to the facility on [DATE], with diagnoses of schizoaffective disorder (a mental illness that causes loss of contact with reality) bipolar type (mental disorder characterized by episodes of mania [extreme highs] and depression [extreme lows]), anxiety disorder (persistent and excessive worry that interferes with daily activities), and hemiplegia (a condition caused by brain damage or spinal cord injury that leads to paralysis [loss of motor function in one or more muscles] on one side of the body) and hemiparesis (weakness on one side of the body) following cerebral infarction (a stroke, damage to tissue in the brain due to loss of oxygen to the area) affecting the left non-dominant side. A review of the MDS, dated [DATE], indicated Resident 52's cognitive (mental action or process of acquiring knowledge and understanding) patterns were intact. The MDS indicated Resident 52 had an impairment in the upper extremity (shoulder, elbow, wrist, hand) and an impairment in the lower extremity (hip, knee, ankle, foot). The MDS indicated Resident 52 was dependent (helper does all of the effort, resident does none of the effort to complete the activity) for oral hygiene, toileting hygiene, shower/bathe self, upper and lower body dressing, putting on/taking off footwear, personal hygiene (combing hair, shaving, washing/drying face and hands), roll left and right, sit to lying, lying to sitting, chair/bed-to-chair transfer, and tub/shower transfer. A review of Resident 52's Care Plan, initiated 5/24/2024, indicated Resident 52 was at risk for further decline in activities of daily living (ADLs) related to hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side. The care plan indicated staff interventions were to assist in transfer, encourage to continue participating in performing ADLs within capability, and explain procedure before and during care. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent observation and interview in Resident 52's room on 6/13/2024 at 3:43 PM, Resident 52 was lying in bed with left arm close to body, left lower arm was positioned towards left side of chest, and the left hand made a fist. Resident 52 stated since he had a stroke, his left arm, left hand, and left leg could not move. Resident 52 stated he was admitted to the facility about a month ago and no one had come to move or do any exercises to his left arm and left legs, and it felt more stiff and painful since they were not moved. Resident 52 asked if there was any way he could get help with exercising his arm, hand, hip, and leg. Resident 52 stated no one had asked him if he wanted assistance with range of motion on his left side since admission. Resident 52 stated he wanted to get out of bed, but staff never asked or assisted him out of bed. Resident 52 stated he wanted to go out of his room, but he did not have a wheelchair and required assistance. Resident 52 stated he had been lying in bed since he was admitted on [DATE]. During an interview on 6/13/2024 at 3:51 PM with Registered Nurse 4 (RN 4), RN 4 stated when residents had a limited range of motion, the doctor should be notified so the rehabilitation team could evaluate the resident. RN 4 stated she admitted Resident 52 on 5/24/2024 and that Resident 52 had limited range of motion on the left arm and left leg. RN 4 stated Resident 52's left hand was contracted. During concurrent record review and interview on 6/13/2024 at 4:12 PM of Resident 52's care plan with RN 4, RN 4 stated a care plan was only created for Resident 52's ADLs. RN 4 stated Resident 52's care plan should specify the interventions since Resident 52 had immobility on the left side. RN 4 stated a care plan for limited range of motion on the left side should be included along with interventions for the limited range of motion. RN 4 stated communication and coordination of care for Resident 52 was important to allow Resident 52 to have basic needs of life to ensure quality of life and quality of care. During an interview on 6/14/2024 at 8:46 AM with Restorative Nursing Assistant 2 (RNA 2), RNA 2 stated Resident 52 was bed bound. RNA 2 stated Resident 52's left hand was contracted. RNA 2 stated Resident 52's arm looked like he was hugging his body. RNA 2 stated RNA services would be beneficial for Resident 52 to receive when he was initially admitted since Resident 52 was very contracted. RNA 2 stated RNA services would help prevent Resident 52 from becoming more contracted. During an interview on 6/14/2024 at 10:13 AM with RN 2, RN 2 stated it was important for Resident 52 to perform exercise to the area with limited range of motion to promote blood circulation. RN 2 stated the plan would help in preventing any complications that could result from being immobile. RN 2 stated since there was no plan of care and interventions provided for Resident 52's limited range of motion for the past three weeks, this would result in a large decline in Resident 52's ADLs. RN 2 stated this would not assist in Resident 52's stroke recovery. During a concurrent interview and record review of Resident 52's MDS on 6/14/2024 at 12:14 PM with the Minimum Data Set Nurse (MDSN), MDSN stated Resident 52 had a functional limitation in range of motion. MDSN stated Resident 52 had an impairment on one side of the upper extremity and an impairment on the lower extremity. MDSN stated a care plan should be included for Resident 52's limited range of motion. MDSN stated if the care plan is specific for Resident 52's needs will help the nurses to know the limited range of motion on Resident 52's left side if the body and how to care for the part of the body. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the facility's policy and procedure titled, Comprehensive Person-Centered Care Plans, revised 4/24/2024, indicated each resident's comprehensive person-centered care plan is consistent with the resident's rights to participate in the development and implementation of his or her plan of care, including the right to participate in establishing the expected goals and outcomes of care. The resident is informed of his or her right to participate in his or her treatment and provide advanced notice of care planning conference.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44636 Based on observation, interview, and record review, the facility failed to update and revise the care plans for two of 23 sampled residents in accordance with the facility policy by failing to ensure: 1. Resident 64's care plan was revised when the diet was changed. 2. Resident 63's dialysis (a lifesaving treatment for residents with kidney failure) care plan was updated and revised to address intake and output (I & O) monitoring. These deficient practices have the potential to negatively affect the provisions of care and services for the residents. Findings: 1. A review of Resident 64's Admission Record indicated Resident 64 was admitted to the facility 5/7/2024, with diagnoses of malignant (cancerous) neoplasm (abnormal growth of cells in the body) of unspecified part of unspecified bronchus (one of the two tubes that carry air into the lungs from the trachea) or lung, pleural effusion (fluid buildup in the space between the lung and the chest wall), and atelectasis (collapse of a lung or part of a lung due to air loss in the air sacs). A review of Resident 64's Minimum Data Set (MDS, a standardized assessment and care planning tool), dated 5/20/2024, indicated Resident 64's cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decision making were moderately impaired. The MDS indicated Resident 64 required supervision or touching assistance (helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity) for eating. The MDS indicated Resident 64 was dependent (helper does all of the effort, resident does none of the effort to complete the activity) for sit to stand and chair/bed-to-chair transfer. The MDS also indicated Resident 64 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) for toilet hygiene, shower/bathe self, roll left and right, sit to lying, and lying to sitting on side of bed. A review of Resident 64's Care Plan, initiated 5/24/2024, indicated Resident 64 had a nutritional problem or potential nutritional problem. The care plan interventions were to provide and serve diet as order, provide food preferences per menu, and regular diet texture thin liquids consistency. A review of Resident 64's Physician's Orders are as follows: - 5/8/2024, regular diet regular diet texture, thin liquids consistency. - 6/3/2024, NPO (nothing by mouth, no consumption of any food or liquids) as today due to unable to swallow. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- 6/5/2024, thin liquids as tolerated for oral gratification, aspiration (inhaling small particles of food or drops of liquid into the lungs) precaution. During a current interview and record review on 6/14/2024 at 9:41 AM of Resident 64's Physician's Orders with Licensed Vocational Nurse 2 (LVN 2), LVN 2 stated Resident 64 initially had a regular diet with thin liquids consistency when admitted . LVN 2 stated on 6/3/2024, the physician ordered for Resident 64 to be NPO. LVN 2 stated on 6/5/2024, the physician changed Resident 64's order from NPO to liquids for oral gratification as tolerated. During a current interview and record review on 6/14/2024 at 9:43 AM of Resident 64's care plans with LVN 2, LVN 2 stated Resident 64's care plans indicated Resident 64 was still on a regular diet. LVN 2 stated the care plan should have been updated to reflect Resident 64's current diet of liquids for oral gratification as tolerated. During a concurrent record review of Resident 64's care plan and interview on 6/14/2024 at 11:14 AM with the MDS Nurse (MDSN), MDSN stated the licensed nurse who received the order from the physician to change Resident 64's diet should have updated the care plan. MDSN stated Resident 64's current diet order on 6/5/2024 was for liquids for oral gratification. MDSN stated Resident 64's care plan had not been updated since the care plan still showed Resident 64 had a regular diet. MDSN stated Resident 64's care plan should have been revised with the latest diet order to prevent Resident 64 from eating a regular diet. MDSN stated the continuance of Resident 64's regular diet could cause Resident 64 to aspirate. The MDSN stated Resident 64's care plan for the liquid diet should had been updated on 6/5/2024 when the physician ordered a diet change. A review of the facility's Policy and Procedure (P&P) titled, Food and Nutrition Services, 4/24/2024, indicated a resident-centered diet and nutrition plan will be based on this assessment. A review of the facility's P&P titled, Comprehensive Person-Centered Care Plans, 4/24/2024, indicated assessments of residents are ongoing and care plans are revised as information about the residents and the residents' conditions change. 2. A review of Resident 63's Admission Record indicated Resident 63 was initially admitted to the facility 4/30/2024 and readmitted on [DATE], with diagnoses end stage renal disease (advanced stage kidney failure), chronic kidney disease (gradual loss of kidney damage where kidneys cannot filter the blood the way they should) stage 4 (severe), and hypertension (high blood pressure). A review of Resident 63's Physician Order Summary Report are as follows: - 4/30/2024: Monitor intake and output every shift for 30 days every shift for 30 days. - 4/30/2024: Dialysis on Tuesdays, Thursdays, and Saturdays. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of Resident 63's MDS, dated [DATE], indicated Resident 63's cognitive skills for daily decision making were moderately impaired. The MDS indicated Resident 63 was dependent on toileting hygiene, sit to lying, lying to sitting on side of bed, sit to stand, and chair/bed-to-chair transfer. The MDS indicated Resident 63 required partial/moderate assistance (helper does less than half the effort, helper lifts or holds trunk or limbs and provides more than half the effort) for upper body dressing and personal hygiene (combing hair, shaving, washing/drying face and hands). The MDS indicated Resident 63 was on dialysis. A review of Resident 63's Care Plan, initiated on 4/30/2024, indicated Resident 63 was at risk for complication related to hemodialysis (medical procedure that filters the blood of waste products when the kidneys are not able to) with diagnosis of end stage renal disease. The care plan interventions included were to avoid taking blood pressure or drawing blood samples in shunt (provides vascular access for hemodialysis) extremity, monitor signs and symptoms of bleeding from the access site, I & O monitoring as ordered; monitor I&O every shift every shift for 30 days. During a concurrent review of Resident 63's Physician's Order Summary Report and care plan and interview on 6/14/2024 at 9:53 AM with Registered Nurse 2 (RN 2), RN 2 stated RN 2 stated there were no orders for fluid restriction and fluid monitoring. RN 2 stated Resident 63 had monitoring for I&O for 30 days which was initiated on 4/30/2024. RN 2 stated the I&O monitoring for Resident 63 had been discontinued after the 30 days from 4/30/2024. RN 2 stated Resident 63's physician needed to be contacted for re-evaluation for I&O monitoring and fluid restrictions since Resident 63 was a dialysis resident. RN 2 stated Resident 63's care plan needed to be updated and revised since Resident 63 did not have a care plan for I&O monitoring or fluid restriction for his dialysis condition. During an interview on 6/14/2024 at 11:26 AM with MDSN, MDSN stated since Resident 63 was on dialysis, Resident 63 should be on a fluid restriction. MDSN stated the license nurse needed to contact the physician to verify if the physician wanted to continue monitoring Resident 63's I&O since the admission order only indicated to monitor the I&O for 30 days. The MDSN stated the care plan for Resident 63's dialysis should be updated and revised to include if Resident 63 still needed I&O monitoring and fluid restriction if ordered. The MDSN stated the care plan intervention initiated and revised on 4/30/2024 only included I&O monitoring for 30 days. During an interview on 6/14/2024 at 2:54 PM with the Director of Nursing (DON), the DON stated Resident 63 should have I&O monitoring and fluid restriction included in Resident 63's plan of care. The DON stated the nurses needed to monitor Resident 63's I&O to prevent Resident 63 from fluid overload (condition where body has too much fluid causing the heart to overwork leading to heart failure and buildup of fluid in the lungs) which were potential problems for Resident 63. A review of the facility's P&P titled, Comprehensive Person-Centered Care Plans, 4/24/2024, indicated assessments of residents are ongoing and care plans are revised as information about the residents and the residents' conditions change. The comprehensive person-centered care plan reflects currently recognized standards of practice for problem areas and conditions. A review of the facility's P&P titled, Dialysis Services, revised 4/2024, indicated the facility will provide adequate and appropriate care to dialysis clients in coordination with the dialysis center, under the management and direction of the resident's attending physician. The facility may be required to monitor of fluid gain and loss, including assessment of weight, blood pressure, and intake and output. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the facility's P&P titled, Intake and Output, revised 4/2024, indicated the facility will maintain intake and output record when needed to monitor residents for adequate fluid balance for resident admitted with dialysis and fluid restrictions for 30 days, then re-evaluate and continue with MD order. Residents care plans will be updated, as necessary.

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44636 Based on observation, interview, and record review, the facility failed to provide an activity based on resident's preference and activity assessment for two of two sampled residents (Residents 52 and 29) in accordance with the facility policy. This deficient practice had the potential not to meet Residents 52 and 29's interests and activity needs, which could affect the physical, mental, and psychosocial well-being of each resident. Findings: 1. A review of Resident 52's Admission Record indicated Resident 52 was admitted to the facility on [DATE], with diagnoses of schizoaffective disorder (a mental illness that causes loss of contact with reality) bipolar type (mental disorder characterized by episodes of mania [extreme highs] and depression [extreme lows]), anxiety disorder (persistent and excessive worry that interferes with daily activities), and hemiplegia (a condition caused by brain damage or spinal cord injury that leads to paralysis [loss of motor function in one or more muscles] on one side of the body) and hemiparesis (weakness on one side of the body) following cerebral infarction (a stroke, damage to tissue in the brain due to loss of oxygen to the area) affecting the left non-dominant side. A review of the Minimum Data Set (MDS, an assessment and care screening tool), dated 6/6/2024, indicated Resident 52's cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decision making were intact. The MDS indicated Resident 52 was dependent (helper does all of the effort, resident does none of the effort to complete the activity) for oral hygiene, toileting hygiene, shower/bathe self, upper and lower body dressing, putting on/taking off footwear, personal hygiene (combing hair, shaving, washing/drying face and hands), roll left and right, sit to lying, lying to sitting, chair/bed-to-chair transfer, and tub/shower transfer. The MDS indicated Resident 52's activity preferences for very important included listening to music, doing favorite activities, and going outside to get fresh air when the weather was good. A review of Resident 52's Activity Assessment, dated 5/30/2024, indicated during Resident 52's interview Resident 52 stated it was very important to go outside to get fresh air when the weather was good. A review of Resident 52's Care Plan, initiated 5/30/2024, indicated activity participation was complicated by activity intolerance related to body weakness and mobility impairment. The care plan interventions were to assess the resident's activity preference, provide a monthly calendar in room, and assist the resident to group activities. During a concurrent observation and interview in Resident 52's room on 6/13/2024 at 3:43 PM, Resident 52 was lying in bed. Resident 52 stated he wanted to get out of bed, but staff never asked or assisted him out of bed. Resident 52 stated he wanted to go out of his room, but he did not have a wheelchair and required assistance. Resident 52 stated he had lying in bed since he was admitted on [DATE]. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 6/14/2024 at 3:34 PM of Resident 52's Activity Assessment with the Director of Nursing (DON), the DON stated the Resident 52 indicated it was very important for Resident 52 to go outside. The DON stated the Activities Director (AD) did not and needed to communicate with the nursing, hospice, and rehab team about Resident 52's activity preference. A review of the facility's Policy and Procedure titled, Activity Program, revised 4/24/2024, indicated our activity program consists of individual, and small and large group activities which are designed to meet the needs and interests of each resident and includes outdoor activities. 48152 2. A review of Resident 29's Admission Record indicated Resident 29 was readmitted to the facility on [DATE] with diagnoses that included dysphagia (difficulty swallowing), neuromuscular dysfunction of bladder (a condition when a person does not have bladder control because of brain, spinal cord, or nerve problems), gastrostomy (a surgical creation of an opening in the abdominal wall into the stomach for drainage or a feeding tube), and anemia (a condition in which the blood doesn't have enough healthy red blood cells and hemoglobin to carry oxygen all through the body). A review of Resident 29's History & Physical (H&P), dated 4/27/2024, indicated Resident 29 had fluctuating capacity to understand and make decisions. The H&P also indicated Resident 29 as blind. A review of Resident 29's Minimum Data Set (MDS - a standardized resident assessment care screening tool), dated 5/8/2024, indicated Resident 29 had a moderately impaired cognitive (ability to make decisions regarding tasks of daily life) skills for daily decision making. Resident 29 was assessed with highly impaired vision and was dependent (resident does none of the effort to complete the activity) with oral/personal hygiene, toileting, bathing, and dressing. A review of Resident 29's Activity Assessment, dated 4/29/2024, indicated it was very important to Resident 29 to go outside when the weather is good, to participate in religious services or practices, to keep up with the news and to participate in his favorite activities. The assessment also indicated it is somewhat important to Resident 29 to listen to music he likes and do things with groups of people and not very important to Resident 29 to have books, newspapers, and magazines for reading. A review of Resident 29's Interdisciplinary Team (IDT) Care Conference Notes, dated 5/1/2024, indicated Resident will be provided resident room visits/sensory stimulation three (3) times per week. During an interview on 6/12/2024 at 8:52 AM with Resident 29, Resident 29 stated he does not have any entertainment from facility including radio and would like that to change. During an interview on 6/14/2024 at 10:56 AM Licensed Vocational Nurse 1 (LVN) 1, LVN 1 stated activities provided for Resident 29 included staff visits in the resident's room, and magazines to read for activities. LVN 1 also stated Resident 29 is legally blind (level of visual impairment that limits the activities performed by individuals without assistance). During an interview on 6/14/2024 at 11:38 AM with Resident 3 (Resident 29's roommate), Resident 3 stated when activities staff visit Resident 29, they talk with him but have not heard or seen activities staff provide resident 29 with a radio to listen to music. (continued on next page)

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	555213	A. Building B. Wing	06/14/2024

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

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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 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 6/14/2024 at 12:03 PM with Activities Director (AD), AD stated Resident 29 receives activities of hand massage and magazines. AD also stated Resident 29 does not have a radio to listen to, but she advised the resident to listen to the televisions of his roommates for his audio activities. During a concurrent record review of Resident 29's Comprehensive Care Plan and interview on 6/14/20244 at 2:57 PM, with Registered Nurse 1 (RN) 1, RN 1 stated the facility failed to indicate a care plan for Resident 29's activities. RN 1 stated there was no activity care plan for Resident 29. RN 1 stated a care plan should have been developed to include Resident 29's tolerance to activities, goals, interventions like assessments, indications of appropriate activities and the results of the evaluations. RN 1 also stated without a care plan directed to the activities for Resident 29, facility is not providing the complete care Resident 29 should be receiving due to the lack of care plan for activities. A review of the facility Policy and Procedure (P&P) titled, Activity Program, revised 4/24/2024, indicated facility will provide individualized and group activities that reflect the choices, rights, cultural and religious interests of the residents.

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assist a resident in gaining access to vision and hearing services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46919 Based on interview and record review, the facility failed to assist one (1) of two sampled residents (Resident 12) in making appointment of vision services as ordered by the physician. This deficient practice resulted in Resident 12 not having his vision examined to maintain and/or improve his vision. Findings: A review of Resident 12's Admission Record indicated Resident 12 was admitted to the facility on [DATE] with diagnoses that included unspecified cataract (a cloudy area in the clear part of the eye that helps to focus light)and unspecified glaucoma (the result of pressure of the eye that damages the nerve that carries messages from the retina to the brain which can lead to permanent vision loss or blindness). A review of Resident 12's History and Physical Examination (H&P), dated 2/7/2024, indicated Resident 12 had fluctuating capacity to understand and make decisions. A review of Resident 12's Minimum Data Set (MDS, a standardized assessment and care planning tool), dated 5/21/2024, indicated Resident 12 had intact memory and cognition (mental action or process of acquiring knowledge and understanding) skills for daily decision making and required substantial/maximal assistance (helper does more than half the effort) with toileting hygiene, lower body dressing, putting on/taking off footwear, sit to stand, and toilet transfer. A review of Resident 12's Care Plan, dated 2/6/2024, indicated Resident 12 was at risk for further impaired vision related to Glaucoma. The Care Plan interventions indicated to keep eye appointments as scheduled. During an interview with Resident 12, on 6/11/2024, at 10:45 AM, Resident 12 stated he had poor vision and needed glasses. Resident 12 stated he was still waiting for the ophthalmologist (physician who examines, diagnoses, and treats the eyes) to come and see him since his admission on 2/6/2024. During a concurrent interview with the Social Services Director (SSD 1) on 6/13/2024, at 8:11 AM, Resident 12's Physician order dated 2/6/2024 was reviewed. SSD 1 stated Resident 12 was ordered for optometry (the practice or profession of examining the eyes for visual defects and prescribing corrective lenses)/ophthalmology (the branch of medicine concerned with the diagnosis and treatment of disorders of the eye) consult as needed on 2/6/2024. SSD 1 stated he has not sent Resident 12's optometry/ ophthalmologist consult order to the ophthalmology clinic because he was busy on the day the consult was ordered. SSD 1 stated Resident 12's optometry/ophthalmologist consult order should have been sent to the ophthalmology clinic as soon as it was ordered by the physician so we can get an appointment for Resident 12. SSD 1 stated it was important for Resident 12 to get his eyes checked as soon as it was ordered to make sure the resident received the procedure and treatment needed for his vision. (continued on next page)

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with Registered Nurse 1 (RN 1), on 6/14/2024, at 3:44 PM, RN 1 stated Resident 12's order for optometry/ophthalmologist consult should have been coordinated with the SSD by the licensed nurse as soon as it was ordered by the physician on 2/6/2024. RN 1 stated SSD was responsible for sending consultation referrals to the physicians. RN 1 stated, for Resident 12 to have to wait for four months for an optometry/ophthalmologist consult was too long. RN 1 stated it was important for Resident 12 to get an appointment with optometry/ophthalmologist without delay so Resident 12 can receive the correct treatment in a timely manner and to prevent his vision from deteriorating. A review of the facility's policy and procedure (P&P), titled, Visually Impaired Resident, Care of, revised on 4/24/2024, indicated, Residents with visual impairment will be assisted with activities of daily living as appropriate. The P&P also indicated, while it is not required that our facility provide devices to assist with vision, it is our responsibility to assist the resident and representatives in scheduling appointments and arranging transportation to obtain needed services.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46919 Based on observation, interview and record review, the facility failed to ensure three of four sampled residents (Resident 37, 48, and 60) were provided necessary treatment and services to prevent formation of and promote healing of pressure injury (pressure ulcers- injury to the skin and underlying tissue resulting from prolonged pressure on the skin) in accordance with the facility's policy and procedure (P&P) and physician's order by: 1. Facility failed to ensure Resident 37's low air loss mattress (LALM/ LAL mattress- an air mattress covered in tiny holes designed to let out air very slowly which helps keep the skin dry and [NAME] away any moisture) was set up according to the resident's weight. Resident 37 was observed with the LALM set at approximately 200 pounds ([lbs]- unit of measurement) and Resident 37 weighed 121 lbs. This deficient practice placed Resident 37 at risk to develop pressure injury. 2. Failed to reposition Resident 48 every two (2) hours as per physician order and plan of care. This deficient practice placed Resident 48 at risk for progression of pressure injury and had the potential to cause delayed healing of Resident 48's pressure injuries. 3. Facility failed to obtain an order, and application of LALM for Resident 60 who had a stage 4 pressure ulcer (full thickness tissue loss with exposed bone, tendon, or muscle), since admission in the facility on 5/3/2024. Findings: 1. A review of Resident 37's Admission Record indicated Resident 37 was initially admitted to the facility on [DATE] and was readmitted on [DATE] with diagnoses that included benign lipomatous neoplasm (a non-cancerous lump that forms due to an overgrowth of fat cells), type 2 diabetes mellitus (a disease that occurs when the blood sugar is too high), and hemiplegia (paralysis on one side of the body) and hemiparesis (weakness or the inability to move one side of the body) following unspecified cerebrovascular disease affecting left non-dominant side (a group of disorders that affect the blood vessels and blood supply to the brain). A review of Resident 37's History and Physical Examination (H&P), dated 6/23/2023, indicated Resident 37 had the capacity to understand and make decisions. A review of Resident 37's Minimum Data Set (MDS, a standardized assessment and care planning tool), dated 4/10/2024, indicated Resident 37 had intact memory and cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decision making and was dependent (helper does all of the effort, resident does none of the effort to complete the activity) with toileting hygiene, shower/bathe self, upper body dressing, lower body dressing, and personal hygiene. A review of Resident 37's Braden Scale for Prediction of Pressure Sore Risk, with an observation date 4/10/2024, indicated Resident 37 had a score of 14 which indicated Resident 37 was at moderate risk for developing pressure injuries. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of Resident 37's Order Summary Report, dated 6/14/2024, indicated a physician order, with a start date of 6/24/2022, to have LALM for skin maintenance. A review of Resident 37's Weight and Vitals Summary, dated 6/14/2024, indicated Resident 37 weighed 121 lbs. on 6/6/2024. During a concurrent observation of Resident 37's room and interview with Restorative Nurse Assistant 1 (RNA 1), on 6/11/2004, at 10:04 AM, Resident 37 was observed in bed with the LALM pressure adjustment knob at 220 lbs. RNA 1 stated the LALM setting was approximately 220 lbs. which was too high for Resident 37. RNA 1 stated Resident 37 only weighed around 120 lbs. During a concurrent interview with the Infection Preventionist Nurse (IPN) and record review, on 6/12/2024, at 4:59 PM, Resident 37's weight taken on 6/6/2024 was reviewed on the electronic medical record (EMR). The IPN stated Resident 37 weighed 121 lbs. on 6/6/2024. The IPN stated the LALM setting should be based on the Resident 37's weight. The IPN stated a LALM setting of approximately 200 lbs. was too high for Resident 37 and the LALM pressure adjustment knob arrow should be pointed below 140 lbs. During the same interview with IPN on 6/12/2024 stated a LALM was used for skin maintenance, wound management, pressure injury prevention, and to prevent a pressure injury from getting worse. The IPN stated having the wrong LALM setting defeats the purpose of what a LALM is used for. The IP stated licensed nurses were responsible for making sure the LALM was on the correct setting. During an interview with Treatment Nurse (TN), on 6/13/2024, at 3:44 PM, TN stated the LALM setting should be based on the resident's weight. TN stated a LALM prevents pressure injuries by distributing the resident's body weight on the bed. TN stated it is important for the LALM to be at the correct setting to prevent pressure injuries from getting worse and to help with the resident's circulation. A review of the facility's P&P, titled, Policy and Procedure on Air Loss Mattress, revised on 4/24/2024, indicated the facility will ensure that resident skin integrity is maintained and to aid in healing decubitus ulcer. The P&P indicated, The air pressure of the air loss mattress will be adjusted based on the resident's weight to serve its purpose. 2. A Review of Resident 48's Admission Record indicated Resident 48 was initially admitted to the facility on [DATE] and was readmitted on [DATE] with diagnoses that included sepsis (infection of the blood), pressure ulcer of left buttock stage 2 (open wounds like an ulcer with swelling, discoloration, and pain), pressure ulcer of sacral region stage 4, and pressure ulcer of left ankle stage 4. A review of Resident 48's MDS, dated [DATE], indicated Resident 48 had severely impaired cognitive skills for daily decision making and was dependent with toileting hygiene, shower/bathe self, upper/lower body dressing, personal hygiene, rolling left and right, sit to lying, and lying to sitting on side of bed. A review of Resident 48's Braden Scale for Prediction of Pressure Sore Risk, with an observation date 4/26/2024, indicated Resident 48 had a score of 11 which indicated Resident 38 was a high risk for developing pressure injuries. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of Resident 48's Care plan, dated 4/5/2024, indicated Resident 48 was at risk for skin breakdown related to (r/t) diabetes mellitus (DM- a disease that occurs when the blood sugar is too high), capillary (delicate blood vessels that are found throughout the body) skin fragility, admitted with pressure injuries. Care Plan interventions indicated to turn and reposition every 2 hours and to keep bony prominences from direct contact with one another will pillows and other soft material to relieve pressure. A review of Resident 48's Care plan, dated 4/8/2024, indicated Resident 48 was admitted with pressure injury unstageable (base of the wound is covered by a layer of dead tissue that may be yellow, grey, green, brown, or black that is why it is difficult to determine the stage) on right lateral 4th toe. Care Plan interventions indicated to turn and reposition every (q) 2 hours and as needed. A review of Resident 48's Care plan, dated 4/8/2024, indicated Resident 48 was admitted with pressure injury stage 4 on left lateral malleolus and another care plan for the resident's stage 4 on sacrum (the triangular bone at the base of the spine). Care Plan interventions indicated to turn and reposition q2 hours and as needed. A review of Resident 48's Care plan, dated 4/8/2024, indicated Resident 48 was at risk for infection related to Moisture-associated skin damage (MASD- inflammation or skin erosion caused by prolonged exposure to a source of moisture such as urine, stool, sweat, wound drainage, saliva, or mucus) on left buttock. Care Plan interventions indicated to keep pressure off of skin, turn and reposition at least every 2 hours and as needed. During an interview with the IPN, on 6/12/2024, at 5:10 PM, the IPN stated Resident 48 had sacral, foot, knee, and abdominal wounds. During an observation of Resident 48, on 6/13/2024, at 9:02 AM, Resident 48 was observed asleep in bed. Resident 48 was on her back while slightly leaning towards the left side of the bed. During an observation of Resident 48, on 6/13/2024, at 12:41 PM, Resident 48 was observed asleep in bed. Resident 48 was on her back while slightly leaning towards the left side of the bed (same position when seen at 9:02 AM). During a concurrent observation and interview of Resident 48, on 6/13/2024, at 2:32 PM, Resident 48 was awake in bed. Resident 48 continued to be on her back and slightly leaning towards the left side of the bed. Resident 48 stated she does not like getting turned in bed. Resident 48 stated no one has turned her in bed today. Resident 48 sated she has been laying on her back all day. During a concurrent observation and interview with Resident 48 and Certified Nurse Assistant 9 (CNA 9), on 6/13/2024, at 2:57 PM, CNA 9 stated Resident 48 did not like to be turned in bed because of pain CNA 9 stated he placed a pillow under Resident 48's back sometime this morning to offload (minimize or remove weight to help prevent and heal ulcers). Resident 48 stated CNA 9 did not place a pillow under her back this morning. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview with Licensed Vocational Nurse 1 (LVN 1) and record review of Resident 48's care plan for risk for skin breakdown r/t DM dated 4/5/2024, on 6/13/2024, at 3:02 PM, LVN 1 stated Resident 48 screams and refuses to be turned every 2 hours in bed. LVN 1 stated Resident 48 had multiple wounds and pressure injuries on her left side, and it was important for Resident 48 to be turned every 2 hours in bed to prevent her pressure injuries from worsening. LVN 1 stated it was important for Resident 48 to have a care plan that addressed Resident 48's refusal to be turned every 2 hours in bed so facility staff knows what other interventions to follow when Resident 48 refuses to be turned in bed. LVN 1 stated licensed nurses and the Minimum Data Set Nurse (MDSN) were responsible for creating and revising care plans. LVN 1 stated Resident 48 did not have a care plan that addressed Resident 48's refusal to be turned in bed. During an interview with Treatment Nurse (TN), on 6/13/2024, at 3:50 PM, TN stated Resident 48's wounds are on the left side of her body. TN stated Resident 48 favored her left side and always leaned towards her left when in bed. TN stated it was important to turn Resident 48 every 2 hours in bed to promote wound healing. During a follow up interview with CNA 9, on 6/14/2024, at 12:19 PM, CNA 9 stated he was assigned to Resident 48 today. CNA 9 stated he has not turned Resident 48 today. CNA 9 stated it was important to turn Resident 48 every 2 hours because the resident had multiple wounds. CNA 9 stated the purpose of turning Resident 48 was to promote healing and prevent her wounds from opening up or getting worse. CNA 9 stated the charge nurse should be informed when Resident 48 refuses to be turned every 2 hours in bed. During an interview with Registered Nurse 1 (RN 1), on 6/14/2024, at 4:01 PM, RN 1 stated residents with pressure injuries should be turned every 2 hours in bed to prevent the development and progression of the pressure injury. RN 1 stated facility staff should attempt to turn the resident three (3) times and educate the resident on the benefits of turning if a resident refuses to be turned. RN 1 stated facility staff should also inform the charge nurse or the nursing supervisor if the resident continued to refuse to be turned after the third attempt. During the same interview with RN 1 on 6/14/2024 at 4:01 PM, RN 1 stated the Resident 48's physician and responsible party should have been informed if the resident continued to refuse to be turned every 2 hours in bed. RN 1 added, there was not documented evidence to show that facility have called Resident 48's physician regarding not being able to reposition the resident every 2 hours. RN 1 stated Resident 48's refusal to be turned every 2 hours in bed should be documented and care planned with resident specific interventions that staff can follow. A review of the facility's P&P, titled, Care Plans, Comprehensive Person-Centered, revised on 4/24/2024, 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. The P&P indicated, Assessments of residents are ongoing and care plans are revised as information about the residents and the residents' conditions change. The P&P further indicated, The interdisciplinary team reviews and updates the care plan when there has been a significant change in the resident's condition. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the facility's P&P, titled, Pressure Ulcer Treatment, revised on 4/2024, indicated, It is the policy of the facility to provide guidelines for the care of existing pressure ulcers and the prevention of additional pressure ulcers. The P&P indicated, Pressure ulcer treatment requires a comprehensive approach including maximizing the potential for healing. The P&P further indicated under Reporting to: Notify the supervisor if the Resident refuses the procedure of interventions. If the Resident is refusing care, an evaluation of the basis for refusal, and the identification and evaluation of potential alternatives is indicated. 46087 3. A review of the admission record indicated Resident 60 was admitted to the facility on [DATE] with diagnoses including diabetes mellitus (high blood sugar), peripheral vascular disease (the reduced circulation of blood to a body part other than the brain or heart), pressure ulcer of right buttocks. A review of Resident 60's Braden Scale for Predicting Pressure Sore Risk assessment (an assessment that was developed to foster early identification of patients at risk for forming pressure sores), dated 3/5/2024, indicated a score of 15 which means that Resident is at risk for developing pressure ulcer/injury. The form did not indicate interventions were checked for skin and ulcer treatments. A review of Resident 60's Care Plan, initiated on 3/5/2024, revised on 4/18/202, indicated Resident 60 was admitted with pressure injury stage 4 on right ischium (bone forming the lower and back sides of the hip bone). The Care Plan indicated interventions included were to provide treatment as doctor's ordered and turn and reposition every 2 hours as needed . A review of Resident 60's Minimum Data Set (MDS, standardized care and screening tool), dated 3/17/2024, indicated Resident 60's cognitive skills (processes of thinking and reasoning) for daily decision making was moderately impaired. The MDS indicated Resident 60 was dependent (helper does all the effort) on toileting, shower /bath self, lower body dressing, and putting on/taking off socks. The MDS also indicated the resident was at risk for developing pressure ulcer/ injuries and the resident has 1 or more unhealed pressure ulcers / injuries. The MDS also indicated skin and ulcer/ injury treatment included pressure reducing device for chair, pressure reducing device for bed, turning/ repositioning program, nutrition hydration intervention to manage skin problems, and pressure injury care. During an observation in Resident 60's room on 6/11/2024 at 4 PM, Resident 60 was observed in bed sleeping with no LAL mattress. During a concurrent observation in Resident 60's room and interview with Resident 60 on 6/12/2024 at 7:40 AM, Resident 60 stated, she has a deep wound on her back, she stated that's she's been on the same mattress since she was admitted in the facility. Resident 60 was not ono LAL mattress at this time. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent observation in Resident 60's room and interview on 6/14/2024 at 8:24 AM with the Treatment Nurse (TN), TN confirmed that LAL mattress was newly placed yesterday (6/13/2024). TN stated Resident 60 has stage 4 pressure injury in right ischium since admission on 3/5/2024. TN stated she forgot to inform Resident 60's primary physician and obtain an order to apply LAL mattress since Resident 60's admission in the facility on 3/5/2024. TN stated that LAL mattress is important especially for Resident 60, the resident should be in LAL mattress because of the resident's pressure injury and to prevent worsening of the resident's pressure injury. During a concurrent record review of Resident 60's order summary report as of 6/10/2024, and interview with Registered Nurse 1 (RN 1) on 6/14/2024 at 1:45 PM, RN 1 stated Resident 60 has no order to be placed in LAL mattress. RN 1 stated that for Resident 60 who was admitted with a stage 4 pressure injury in right ischium, order of LAL mattress should have been obtained from the resident's primary physician. RN 1 stated that LAL mattress could lower the risk for further skin breakdown, prevent deterioration of wound because LAL mattress provides less pressure on resident's bony prominences (areas where bones are close to the surface). A review of the facility's Policy and Procedure (P&P) titled, Policy and Procedure on air loss mattress, revised on 4/24/2024, policy indicated to ensure that resident skin integrity is maintained and to aid in healing decubitus ulcer. The P&P indicated the following procedure: 1. Assessment of resident admitted or in house with stage 3 and 4. Based on assessment, appropriate intervention will be implemented. 2. Doctor (MD/ primary physician) will be notified by the licensed nurse. Skin assessment result especially the stage 3 and 4 decubitus ulcers (a bed sore, the consequence of lying or sitting in one position too long) noted during assessment. 3. Pressure relieving device, while in bed or up in wheelchair, will be applied based on MD's order and as nursing intervention. 4. Air Loss Mattress will be applied on the resident's bed as MD's order which will aid in the healing process and wound management. A review of the facility's P&P titled, Pressure Ulcer Treatment, revised April 2024, indicated It is the policy of the facility to provide guidelines for the care of existing pressure ulcers and the prevention of additional pressure ulcers. It also indicated that the pressure ulcer treatment program should focus on the following strategies: a. Assessing the resident and the pressure ulcer(s). b. Managing tissue loads. c. Pressure ulcer care.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. 44636 Based on observation, interview, and record review, the facility failed to provide necessary respiratory care services for one of two sampled resident (Resident 26) by failing to ensure Resident 26's nebulizer mask (a drug delivery device used to deliver drugs in the form of atomized inhalation into the lungs) and tubing were changed weekly per facility's policy. This deficient practice had the potential for Resident 26 to develop a respiratory infection. Findings: A review of Resident 26's Admission Record indicated Resident 26 was admitted to the facility 5/3/2024, with diagnoses of atrial fibrillation (an irregular, often rapid heart rate that commonly causes poor blood flow), hypothyroidism (condition in which the thyroid gland does not produce enough thyroid hormone), and anxiety disorder (persistent and excessive worry that interferes with daily activities). A review of Resident 26's Minimum Data Set (MDS, a standardized assessment and care planning tool), dated 5/16/2024, indicated Resident 26's cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decision making were severely impaired. The MDS indicated Resident 26 was dependent (helper does all of the effort, resident does none of the effort to complete the activity) for oral hygiene, toileting hygiene, shower/bathe self, upper and lower body dressing, personal hygiene (includes combing hair and washing/drying face and hands), sit to lying, lying to sitting on side of bed, sit to stand, and chair/bed-to-chair transfer. A review of Resident 26's Physician Order Summary Report, dated 6/13/2024, indicated Albuterol Sulfate (a bronchodilator that relaxes muscles in the airways and increases air flow to the lungs) Inhalation Nebulization (changes medication from a liquid to a mist that can be inhaled into the lungs) Solution 0.63 milligram (mg, unit of measurement)/three milliliter (ml, unit of volume) - Three ml inhale orally via nebulizer (a device for breathing mist treatment) every six hours as needed for wheezing (a high-pitched, lung sound produced by airflow through an abnormally narrowed or compressed airway)/shortness of breath (SOB) for 30 days. During an observation on 6/11/2024 at 10:26 AM in Resident 26's room, Resident 26's used nebulizer mask was placed on the nightstand table not labeled with date or covered in a bag. The nebulizer mask had multiple white spots all over the inside of the nebulizer mask. During a concurrent observation in Resident 26's room and interview on 6/11/2024 at 11:39 AM with Licensed Vocational Nurse 2 (LVN 2), LVN 2 stated resident's nebulizer mask and tubing were not and should have been dated. LVN 2 stated Resident 26 used the nebulizer this morning. LVN 2 stated the used nebulizer mask was placed directly on top of the nightstand table. (continued on next page)

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

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 6/14/2024 at 10:10 AM with Registered Nurse 2 (RN 2), RN 2 stated the nebulizer mask should be placed in a plastic bag after resident use. RN 2 stated the tubing and the bag holding the nebulizer mask should be dated. RN 2 stated without a date on the tubing and mask, there was no way to tell how old and how long they have been used. RN 2 stated continued use of the nebulizer mask and tubing could be a source of infection for Resident 26. RN 2 also stated the nebulizer mask should not be placed directly on the nightstand to prevent infection and should be placed in a dated plastic bag. During an interview on 6/14/2024 at 3:15 PM with the Director of Nursing (DON), the DON stated nebulizer and tubing should be dated and changed weekly. The DON stated the nebulizer mask should be placed in a plastic bag after use to prevent any cross contamination (the process where bacteria or other microorganisms are unintentionally transferred from one substance or object to another with harmful effect). The DON stated when the nebulizer and tubing are not changed weekly and not properly stored, it could result in the respiratory distress and an infection for the resident. A review of the facility's Policy and Procedure titled, Oxygen Therapy, revised 4/2024, indicated oxygen tubing is to be replaced once a week. Oxygen masks or nasal prongs are to be replaced once a week. Replace oxygen mask or oxygen cannula as necessary if indication of contamination.

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F 0698

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

Provide safe, appropriate dialysis care/services for a resident who requires such services.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 46087

Based on observation, interview, and record review, the facility failed to provide two of two sampled residents (Resident 63 and 60) safe and appropriate care for the provision of dialysis (a lifesaving treatment for residents with kidney failure) consistent with professional standards of practice by:

1.a. Facility failed to assess Resident 60's left upper chest dialysis catheter (a catheter [thin tube] that is placed under the skin in a vein, allowing long-term access to the vein) on 5/14/2024 and 6/1/2024, in accordance with the facility's policy.

1.b. Facility failed to revise Resident 60's dialysis care plan when the resident's left upper arm Antero ventricular shunt (AV shunt, (vascular access in patients receiving regular hemodialysis) vascular access in patients receiving regular hemodialysis) was placed on 5/29/2024. These deficient practices had the potential for unnoticed or missed excessive bleeding and infection on the Resident 60's dialysis access sites.

2. Facility failed to ensure the following for Resident 63:

a. Resident 63's order for intake and output was re-evaluated after 30 days and continued per physician's order.

b. Facility failed to ensure licensed nurses contacted the physician for fluid restriction for dialysis Resident 63.

c. Resident 63's intake and output record were documented per facility policy and procedure.

d. Facility failed to ensure an Interdisciplinary Team (IDT, a group of healthcare professionals from diverse fields who work in a coordinated manner toward a common goal for the resident) was conducted to discuss Resident 63's medical treatment and nurse plan of care.

Findings:

1. A review of the admission record indicated Resident 60 was admitted to the facility on [DATE] with diagnoses that included end stage renal disease (kidneys suddenly become unable to filter waste products from your blood that can develop rapidly over a few hours or a few days), peripheral vascular disease (the reduced circulation of blood to a body part other than the brain or heart), and hypertension (high blood pressure).

A review of Resident 60's Minimum Data Set (MDS, standardized care and screening tool), dated 3/17/2024, indicated Resident 60's cognitive skills (processes of thinking and reasoning) for daily decision making was moderately impaired. The MDS indicated Resident 60 was dependent (helper does all the effort) on toileting, shower /bath self, lower body dressing, and putting on/taking off socks.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of Resident 60's order summary report dated 6/14/2024, indicated dialysis order that consist of left upper chest permacath (a special catheter used for short-term dialysis treatment) and chair time every Tuesday, Thursday, and Saturday at 9 AM ordered on 3/5/2024. During a concurrent record review of Resident 60's dialysis communication records, dated 5/14/2024 and 6/1/2024, and interview with Registered Nurse 3 (RN 3) on 6/14/2024 at 6:05 PM, RN 3 stated Resident 60's dialysis communication record on 5/14/2024 indicated a documentation of right upper chest access site location. RN 3 also stated, it was also documented that bruit (a sound created when blood flows through a narrowed space) were present and audible, and thrill (vibration caused by blood flow) were normal. RN 3 also verified that on the same dialysis communication record, the following questions were not answered in the pre dialysis assessment and communication: - Time left. - Time unto when was the fasting blood sugar was obtained and insulin dosage was left blank. RN 3 stated Resident 60's access site documentation on 5/14/2024 was incorrect and incomplete . RN 3 stated Resident 60's correct type of dialysis access site which is left upper chest catheter and not on the right upper chest. RN 3 added the bruit, and thrill assessment should have not circled because Resident 60 did not have a AV shunt on 5/14/2024. RN 3 stated the documentation might cause confusion when delivering care to Resident 60. RN 3 verified that facility's post dialysis check was not done on 6/1/2024, she added that all licensed nurses can assess Resident when getting back from dialysis center. During the same interview and record review on 6/14/2024 at 6:05 PM, RN 3 stated Resident 60's dialysis communication records dated 6/1/2024, the facility's post dialysis check which should have been done when the resident came back from facility was not filled out. RN 3 stated facility's post dialysis check for Resident 60 should have indicated the following: - Date and time of return. - Mental status - Access site and location - Access site shunt (AV shunt) assessment - Dressing site - Breath sounds - Vital signs - New order - Signature of receiving licenses nurse and date. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent record review of Resident 60's dialysis communication record dated 6/1/2024, and interview with Licensed Vocational Nurse 3 (LVN 3) on 6/14/2024 at 6:15 PM, LVN 3 stated, Resident 60's post dialysis check was not done on 6/1/2024. LVN 3 stated there was no documentation on Resident 60's electronic nurses notes regarding the assessments that is being asked in the facility's post dialysis check. LVN 3 stated the dialysis communication record for Resident 60 should be completed by the charge nurse upon the resident's return from dialysis on 6/1/2024 to know the status of the resident. During a follow up interview with RN 3 on 6/14/2024 at 6:18 PM, RN 3 the facility did not initiate a care plan for Resident 60's newly placed left upper arm AV shunt on 5/29/2024. RN 3 verified that Resident 60's hemodialysis care plan that was initiated on 3/5/2024 did not indicate the resident's dialysis access site on the left upper arm AV shunt. RN 3 stated Resident 60's care plan should have been initiated or revised on 5/29/2024, where in Resident 60's newly placed left upper arm AV shunt and interventions such as no blood draw and blood pressure check in left upper extremity should have been indicated in the care plan. During a concurrent record review of Resident 60's dialysis communication records, dated 5/14/2024 and 6/1/2024, and interview with Director of Nursing (DON) on 6/14/2024 at 6:22 PM, the DON stated since Resident 60 has a left upper chest central line, the assessment on the Dialysis Communication Record for presence of bruit and thrill was a wrong assessment on 5/14/2024. During the same concurrent record review and interview on 6/14/2024 at 6:22 PM, the DON stated, Resident 60's dialysis communication record on 6/1/2024 was incomplete because facility's post dialysis check for Resident was not filled out. The DON stated, it was important to properly assess residents, document accurately, and complete the Dialysis Communication Record to make sure that resident will receive the proper care. The DON stated, The importance of post dialysis check was to make sure that resident's blood pressure did not lower too much. Charge nurses need to check vital signs and dialysis access needs to be observed and documented. The DON stated that hemodialysis care plan should have been initiated or revised for Resident 60 to reflect the presence of left upper arm AV shunt. A review of the facility's form titled, Nurse's Dialysis Communication Record, revised October 2008, indicated facility's post dialysis check is to be filled out by facility's receiving licensed nurse. A review of facility's Policy and Procedure (P&P) titled Dialysis Services, revised April 2024, procedure indicated development and implementation of the residents' plan of care will be done by the Facility in coordination with the dialysis unit. Facility may be required to provide monitoring for signs and symptoms of infection on shunt site for dialysis residents. It also indicated that the assessment of resident before and after dialysis are the following: - Dialysis accesses site for bruit and thrill - Assess for any sign of bleeding or swelling. - Check for any sign of maceration around the access site. - The routine check for any sign and symptoms of infection around the shunt or access site. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	44636 2. A review of Resident 63's Admission Record indicated Resident 63 was initially admitted to the facility 4/30/2024 and readmitted on [DATE], with diagnoses end stage renal disease (advanced stage kidney failure), chronic kidney disease (gradual loss of kidney damage where kidneys cannot filter the blood the way they should) stage 4 (severe), and hypertension (high blood pressure). A review of Resident 63's Physician Order Summary Report are as follows: - 4/30/2024: monitor intake and output (I&O) every shift for 30 days every shift for 30 days. - 4/30/2024: dialysis on Tuesdays, Thursdays, and Saturdays. A review of Resident 63's MDS, dated [DATE], indicated Resident 63's cognitive skills for daily decision making were moderately impaired. The MDS indicated Resident 63 was dependent on toileting hygiene, sit to lying, lying to sitting on side of bed, sit to stand, and chair/bed-to-chair transfer. The MDS indicated Resident 63 required partial/moderate assistance (helper does less than half the effort, helper lifts or holds trunk or limbs and provides more than half the effort) for upper body dressing and personal hygiene (combing hair, shaving, washing/drying face and hands). The MDS indicated Resident 63 was on dialysis. A review of Resident 63's Care Plan, initiated on 4/30/2024, indicated Resident 63 was at risk for complication related to hemodialysis (medical procedure that filters the blood of waste products when the kidneys are not able to) with diagnosis of end stage renal disease. The care plan interventions were to avoid taking blood pressure or drawing blood samples in AV shunt extremity, monitor signs and symptoms of bleeding from the access site, and I&O monitoring as ordered: monitor I&O every shift every shift for 30 days. A review of Resident 63's Medication Administration Record (MAR, a medical record used by healthcare providers to document the administration of a medication or treatment), dated 5/2024, indicated as follows: - 5/1/2024: Total In: 560 cubic centimeters (cc, measurement of volume); Total Out: x 3. - 5/2/2024: Total In: 300 cc; Total Out: 100 cc - 5/3/2024: Total In: 300 cc; Total Out: 100 cc - 5/4/2024: Total In: 560 cc; Total Out: x 2 - 5/5/2024 and 5/6/2024: Total In: not done; Total Out: not done - 5/7/2024: Total In: 500 cc; Total Out: x 3 - 5/8/2024: Total In: 600 cc; Total Out: x 3 - 5/9/2024: Total In: 300 cc; Total Out: 100 cc (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- 5/10/2024: Total In: 300 cc; Total Out: 100 cc - 5/11/2024: Total In: 300 cc; Total Out: 100 cc - 5/12/2024: Total In: 920 cc; Total Out: x 4 - 5/13/2024: Total In: 600 cc; Total Out: x 4 - 5/14/2024: Total In: 470 cc; Total Out: x 3 - 5/15/2024: Total In: 560 cc; Total Out: x 3 - 5/16/2024: Total In: 250 cc; Total Out: 150 cc - 5/17/2024: Total In: 500 cc; Total Out: x 3 - 5/18/2024: Total In: 600 cc; Total Out: x 1 - 5/19/2024: Total In: 620 cc; Total Out: x 5 - 5/20/2024: Total In: 600 cc; Total Out: x 3 - 5/21/2024: Total In: 500 cc; Total Out: x 3 - 5/22/2024: Total In: 600 cc; Total Out: x 3 - 5/23/2024: Total In: 600 cc; Total Out: x 3 - 5/24/2024: Total In: 600 cc; Total Out: x 3 - 5/25/2024: Total In: 380 cc; Total Out: x 3 - 5/26/2024: Total In: not done; Total Out: not done - 5/27/2024: Total In: 600 cc; Total Out: x 3 - 5/28/2024: Total In: 600 cc; Total Out: x 3 - 5/29/2024: Total In: 650 cc; Total Out: x 3 During an observation on 6/11/2023 at 11:42 AM in Resident 63's room, Resident 63's urinal (receptable for urine which includes measurement lines) containing urine was at the bedside. During an interview on 6/13/2024 at 10:25 AM with Certified Nursing Assistant 7 (CNA 7), CNA 7 stated there was no difference with the plan of care for dialysis residents versus residents who did not receive dialysis. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 6/14/2024 at 9:53 AM with Registered Nurse 2 (RN 2), RN 2 stated Resident 63 received dialysis treatment. RN 2 stated nursing staff should monitor dialysis residents' fluid intake, output and if there was any fluid restrictions. RN 2 stated it was necessary to monitor Resident 63's fluids since Resident 63's had kidney failure. RN 2 stated fluid retention (buildup of excess fluid which causes swelling) could result if Resident 63 drank too much water or fluids. RN 2 also stated Resident 63 could have a difficult time producing urine. During the same interview and concurrent review of Resident 63's Physician's Order Summary Report for the month of June 2023 with RN 2 on 6/14/2024 at 9:53 AM, RN 2 stated there were no orders for fluid restriction and fluid monitoring for Resident 63. During the same interview and concurrent review of Resident 63's Hemodialysis Care Plan, initiated on 4/30/2024, with RN 2 on 6/14/2024 at 9:53 AM, RN 2 stated Resident 63 had monitoring for intake and output (I&O) for 30 days which was initiated on 4/30/2024. RN 2 stated the I&O monitoring for Resident 63 had been discontinued after the 30 days from 4/30/2024. RN 2 stated Resident 63's physician should have been conducted after the I&O order was discontinue for re-evaluation and to continue I&O monitoring and fluid restrictions since Resident 63 was a dialysis resident. RN 2 stated Resident 63's care plan needed to be updated and revised since Resident 63 did not have a care plan for I&O monitoring or fluid restriction for his dialysis condition. During an interview on 6/14/2024 at 10 AM with RN 2, RN 2 stated upon admission, dialysis residents' I&Os were monitored for 30 days. RN 2 stated the licensed nurses needed to re-evaluate the resident and contact the physician. to see if the physician wanted to continue the I&O monitoring. RN 2 stated the physician should also be asked if the physician wanted to place Resident 63 on a fluid restriction. During the same interview on 6/14/2024 at 10 AM and review of the Resident 63's SBAR (an acronym for Situation-Background-Assessment-Recommendation is a technique used to provide a framework for communication between members of the health care team) and nurses notes dated from 5/1/2024 to 6/14/2024, did not indicate the licenses nurses had contacted the physician regarding Resident 63's I&O monitoring or fluid restrictions. A concurrent record review of Resident 63's MAR dated 5/2024 with RN 2, RN 2 stated the I&O documentation totaled all of Resident 63's intake and output for each shift. RN 2 stated Resident 63 was able to void in the urinal therefore the total output should be included since the urine could be measured in the urinal. RN 2 stated licensed nurses needed to document the actual measurement of urine output since Resident 63 used a urinal. RN 2 stated staff should not have put x 1, x 2, and x 3 for Resident 63's output. RN 2 stated she was unsure what the recommended intake and output amount were for dialysis residents. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 6/14/2024 at 11:26 AM with the Minimum Data Set Nurse (MDSN), MDSN stated Resident 63 was a dialysis resident. MDSN stated Resident 63 should be on a fluid restriction. A concurrent record review of Resident 63's Physician Order for June 2024 with MDSN, MDSN stated it did not indicate an order for fluid restrictions and the licensed nurse should have contacted the physician and ask if the physician wanted to place Resident 63 on a fluid restriction. MDSN also stated the license nurse also needed to contact the physician to verify if the physician wanted to continue monitoring of Resident 63's I&O since the I&O on the admission order set only monitored the I&O for 30 days. The MDSN stated the care plan for Resident 63's dialysis should be updated and revised to include if Resident 63 still needed I&O monitoring and fluid restriction if ordered. The MDSN stated the care plan for hemodialysis intervention initiated and revised on 4/30/2024 only included I&O monitoring for 30 days. During an interview on 6/14/2024 at 2:54 PM with the Director of Nursing (DON), the DON stated Resident 63's hemodialysis plan of care should include I&O monitoring and fluid restriction. The DON stated the nurses needed to monitor Resident 63's I&O to prevent Resident 63 from fluid overload (condition where body has too much fluid causing the heart to overwork leading to heart failure and buildup of fluid in the lungs) which were potential problems for Resident 63. The DON stated I&O should be continuous and should have contacted Resident 63's physician to verify if the physician wanted to continue or discontinue with the I&O monitoring. The DON stated it was imperative for the nurses to document the actual amount of I&O in cc for Resident 63 and not just the number of times the resident voided for that day or shift. During a concurrent interview and record review on 6/14/2024 at 3:14 PM of Resident 63's IDT notes dated from 4/30/2024 to 6/14/2024 with the DON, the DON stated an IDT meeting was not done for Resident 63. The DON stated IDT meetings were done with the family or resident three to seven days after admission, then quarterly, and as needed. The DON stated the IDT meeting was supposed to be done to discuss Resident 63's expectations and covered all areas of care. A review of the facility's P&P titled, Comprehensive Person-Centered Care Plans, 4/24/2024, indicated assessments of residents are ongoing and care plans are revised as information about the residents and the residents' conditions change. The comprehensive person-centered care plan reflects currently recognized standards of practice for problem areas and conditions. A review of the facility's P&P titled, Dialysis Services, revised 4/2024, indicated the facility will provide adequate and appropriate care to dialysis clients in coordination with the dialysis center, under the management and direction of the resident's attending physician. The facility may be required to monitor of fluid gain and loss, including assessment of weight, blood pressure, and intake and output. A review of the facility's P&P titled, Intake and Output, revised 4/2024, indicated the facility will maintain intake and output record when needed to monitor residents for adequate fluid balance for resident admitted with dialysis and fluid restrictions for 30 days, then re-evaluate and continue with MD order. Residents care plans will be updated, as necessary. A review of the facility's P&P titled, Care Planning/Interdisciplinary Team, revised 4/2024, indicated the Interdisciplinary Team shall meet as necessary to assure that each resident's care plan includes measurable objectives and timetables to meet the resident's medical, nursing, and psychosocial needs as defined on the resident's assessment.

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48152 Based on observation, interview, and record review, the facility failed to assess risk for entrapment (an event in which a resident is caught, trapped, or entangled in the space in or about) and attempt alternatives prior to the use of side rails (adjustable metal or rigid plastic bars that attach to the bed) for two (2) of three (3) sampled Residents (Resident 32 & 61) as indicated on the facility policy. 1. Resident 32 did not have a reassessment for the use of side rails 2. Resident 61 did not have an assessment for the use of side rails. This failure had the potential to result in the inappropriate use of side rails for Resident 32 and 61, which could pose a safety risk and result in injury or harm. Findings: 1. A review of Resident 32's Admission Record indicated Resident 32 was readmitted to the facility on [DATE], with diagnoses that included seizures (a sudden disruption of the brain's normal electrical activity accompanied by altered consciousness and/or other neurological and behavioral manifestations), hemiplegia (paralysis of one side of the body) and hemiparesis (inability to move one side of the body), and cerebral infarction (also known as a stroke; refers to damage to the tissues in the brain due to a loss of oxygen to the area). A review of Resident 32's Minimum Data Set (MDS - a standardized resident assessment care screening tool), dated 3/1/2024, indicated Resident 32 was rarely/never able to express needs or understand others and had moderately impaired cognitive skills for daily decision making. Resident 32 was dependent (staff does all effort needed to complete activity) with toileting, bathing, dressing, oral and personal hygiene. The MDS also indicated Resident 32 was dependent with rolling, position changes and transfers and bed rails are used daily. A review of Resident 32's History & Physical (H&P), dated 4/18/2024, indicated Resident 32 with a changing capacity to understand and make decisions. A review of Resident 32's Order Summary Report, dated 6/14/2024, indicated to use both 1/4 padded upper bilateral side rails as non-restrictive device for mobility aid to assist Resident 32 to turn, reposition, transfer in bed and seizure precaution. A review of Resident 32's care plan titled, 1/4 Padded Side Rails, dated 6/13/2024, indicated a staff intervention to re-evaluate the need for bed rails quarterly (every 3 months). (continued on next page)

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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 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review of Resident 32's Physical Restraint Assessments on 6/13/2024 at 9:16 AM with Registered Nurse 2 (RN 2), RN 2 stated the most current assessment completed was on 11/27/2023. RN 2 stated, The Physical Restraint assessments are protocol for use of side rails up (on both sides) and assessments are done every 3 to four (4) months to assess for safety. RN 1 also stated, The resident should have had another assessment completed in 3/2024. During a concurrent interview and record review of Resident 32's medical chart on 6/13/2024 at 9:44 AM with Minimum Data Set Nurse (MDSN), MDSN stated facility failed to complete Resident 32's Physical Restraint Assessment in 2/2024 and 5/2024. MDSN stated she is responsible for completing the assessments annually and quarterly and did not complete the quarterly assessment for Resident 32 as indicated in facility policy. MDSN stated it was important to complete the assessment to ensure the use of side rails was beneficial and safe for the resident. During an interview on 6/14/2024 at 2:57 PM with RN 1, RN 1 stated the physical restraints assessments were done quarterly to reassess if the resident needs the side rails. RN 1 stated, It is reassessed to evaluate if it is it good for the resident's condition or does the intervention to use bed side rails need to be discontinued. RN 1 also stated, If the assessment is not done, it may cause the resident to experience limited mobility, a type of restraint. 46087 2. A review of Resident 61's Admission Record indicated Resident 61 was originally admitted to the facility on [DATE]. Resident 61's diagnoses included anxiety disorder (persistent and excessive worry that interferes with daily activities), major depressive disorder (depression, is a mood disorder that causes a persistent feeling of sadness and loss of interest), and insomnia (a common sleep disorder that can make it hard to fall asleep or stay asleep). A review of Resident 61's MDS, dated [DATE], indicated Resident 61 was severely impaired with cognitive skills (ability to think, understand, and reason) for daily decision making. The MDS indicated Resident 61 required partial assistance (helper does less than half the effort) with eating, upper body dressing and personal hygiene. It also indicated that Resident 61 required substantial assistance (helper does more than half the effort) with oral hygiene, lower body dressing and putting on/taking off footwear. Resident 61 required maximal assistance (helper does more than half the effort) with rolling left and right in bed. Resident 61 was dependent to staff with bed to chair transfer, toileting hygiene and shower. During an observation on 6/11/2024 at 2:40 PM in Resident 61's room, Resident 61 was observed lying down in bed with his left upper half side rail up. During a concurrent observation and interview on 6/13/2024 at 2:45 PM with Certified Nursing Assistant 6 (CNA 6) inside Resident 61's room, Resident 61 was observed asleep in bed. CNA 6 verified Resident 61's left upper half side rail was up. During a concurrent observation and interview on 6/13/2024 at 2:50 PM with, Licensed Vocational Nurse 2 (LVN 2), inside Resident 61's room, Resident 61 was observed lying in bed with left upper side rail up. LVN 2 stated that the staff keep one side rail up since the resident can turn on his own in bed. (continued on next page)

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 06/14/2024
NAME OF PROVIDER OR SUPPLIER Pasadena Care Center, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 1640 N. Fair Oaks Avenue Pasadena, CA 91103	

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent record review of Resident 61's Electronic Health Record (EHR, an electronic version of a resident's medical history), dated 5/3/2024 to 6/14/2024 and interview with LVN 2 on 6/14/2024 at 10:05 AM, LVN 2 stated Resident 61's EHR did not have an order for the use of side rails. LVN 2 stated that Resident 61 should have an order for side rails so the staff could refer to it for the resident's safety. During a concurrent record review of Resident 61's hospice (care designed to give supportive care to residents in the final phase of a terminal illness and focus on comfort and quality of life, rather than cure) binder and interview with LVN 4 on 6/14/2024 at 10:35 AM, LVN 4 stated that there was no order indicating Resident 61's need for side rails while in bed. A concurrent record review of Resident 61's HER, dated 5/3/2024 to 6/14/2024 and interview with RN 1 on 6/14/2024 at 2:32 PM, RN 1 stated that there was no documentation found in the EHR indicating that Resident 61 was assessed for the use of side rails. RN 1 also stated all four side rails should never be up because it could be considered a restraint and it could also put the resident at risk for getting hurt. RN 1 stated the use of side rails must first be evaluated and assessed for the resident to ensure that it is needed. RN 1 stated this was important to prevent the use of side rails as a restraint for resident safety. RN 1 further stated that after side rails are assessed, a physician order should be obtained, and a care plan should be developed. A review of the facility's Policy and Procedure (P&P) titled, Policy and Procedures - Usage of bedside rails, revised July 2009, the policy indicated the facility assesses every resident admitted in the facility within seven days upon admission, quarterly, annually, and as often as needed. It is done to make sure that all concerns are noted for proper intervention. This includes but is not limited to the proper use of bed side rails. For any purpose of bedside rails usage, it is a must to have consent of the resident/ resident's representative or both and MD order. The facility will ensure that appropriate and proper usage of the bedside rails are implemented for resident benefits.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46087 Cross reference F759 Based on observation, interview, and record review, the facility failed to provide pharmaceutical services to meet the needs of one of seven sampled residents (Resident 50) in accordance with the facility policy by: 1. Failing to administer Dexamethasone (medication that provides relief for inflamed areas of the body) two milligrams (mg, unit of measurement) tablet timely as ordered on 6/14/2024. 2. Failing to administer the following 9 AM due medications on 6/14/2024: a. Cozaar (medication to lower blood pressure) oral tablet 50 mg b. Lasix (medication to treat fluid retention and swelling) oral tablet 20 mg c. Norvasc (medication to lower blood pressure) oral tablet 5 mg d. Docusate Sodium (stool softener) oral Capsule 100 mg e. Levetiracetam (medication to treat seizures [a sudden, uncontrolled burst of electrical activity in the brain]) oral tablet 750 mg f. Lidocaine Patch 4 percent (medication, a patch to relieve pain) These deficient practices had the potential for Resident 50 to experience tachycardia (a fast heartbeat of more than 100 times per minute), high blood pressure, constipation, seizures, and pain, and decline in overall health status. Findings: A review of Resident 50's Admission Record indicated the resident was admitted to the facility on [DATE] with diagnosis including angioneurotic edema (unpredictable frequent edematous episodes of cutaneous and mucosal tissues such as lips, eyes, oral cavity, larynx, and gastrointestinal system), hypertension (high blood pressure), and seizures. A review of the Minimum Data Set (MDS, a standardized assessment and care-screening tool), dated 2/27/2024, indicated Resident 50 had intact cognitive skills (mental action or process of acquiring knowledge and understanding) in decision making. The MDS indicated Resident 50 required partial/moderate assistance (Helper does less than half the effort) from staff with eating. It also indicated that Resident 50 was dependent from staff with oral hygiene, toileting, shower, upper and lower body dressing, putting on/taking off footwear and personal hygiene. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent observation of medication administration and interview with the Licensed Vocational Nurse 1 (LVN 1) on 6/14/2024 at 8:56 AM, LVN 1 was observed preparing the following medications for Resident 50: 1. Dexamethasone 2 mg tablet 2. Eliquis 5 mg tablet (prevents blood clots) 3. Senna 8.6 mg tablet, two tablets (for constipation) 4. Magnesium Citrate (used to treat constipation) 200 mg, half a tablet 5. Gabapentin (used to treat nerve pain) 300 mg capsule, one capsule LVN 1 stated there were five total morning medications to administer for Resident 50. During an observation on 6/14/2024 at 9:18 AM, in Resident 50's room, Resident 50 was observed taking the five medications by mouth with yogurt and fluids. During a concurrent record review of Resident 50's Order Summary Report (a summary of all currently active physician orders) and interview on 6/14/2024 at 10:55 AM, LVN 1 stated he failed to administer the following: 1. Cozaar oral tablet 50 mg, give 1 tablet by mouth one time a day for hypertension. Hold if systolic blood pressure (SBP, the top number in a blood pressure reading) is less than120. With order date of 6/6/2024. 2. Lasix oral tablet 20 mg, give 1 tablet by mouth one time a day for edema. Hold if SBP is less than 110. With order date of 6/7/2024. 3. Norvasc oral tablet 5 mg, give 1 tablet by mouth one time a day for hypertension. Hold if SBP is less than 110. With order date of 6/6/2024. 4. Docusate Sodium oral capsule 100 m. Give 1 capsule by mouth two times a day for bowel management, hold for loose stool. With order date of 6/7/2024. 5. Levetiracetam oral tablet 750 mg. Give 2 tablet by mouth two times a day for Seizures. With order date of 6/6/2024. 6. Lidocaine patch 4 percent for pain. Apply to right hip topically (used on the outside of the body) every 12 hours. With order date of 6/7/2024. LVN 1 stated failing to administer medication to a resident per the physician's order can lead to medical complications possibly resulting in hospitalization . LVN 1 confirmed that the order of dexamethasone oral tablet 2 mg, to give 1 tablet by mouth every eight (8) hours related to malignant neoplasm (abnormal cells grow, multiply and spread to other parts of your body) of brain, with order date of 6/6/2024, was given at 9:18 AM. LVN 1 stated, per physician's order, it should be given at 2 PM. Medication Administration Record indicated that 6 AM dose was already given. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview with Registered Nurse 1 (RN 1) on 6/14/2024 at 2:30 PM, RN 1 confirmed LVN 1 did not give all Resident 50's medication and administered dexamethasone at wrong time. RN 1 added that dexamethasone administration time was scheduled at 6 AM, 2 PM and 10 PM. RN 1 stated that missed blood pressure medications might lead to uncontrolled high blood pressure. RN 1 stated that Resident who was not given Levetiracetam might have seizure. A review of the facility`s Policy and Procedure (P&P) titled, Policy and Procedure in Medication Administration, revised in 7/2013, indicated all medications will be administered following the scheduled medication administration for routine medication unless otherwise specified by Doctor which is different from the routine medication administration schedule. A review of the facility`s P&P titled, Administering Medications, revised in 4/24/2024, indicated a policy that medications are administered in a safe and timely manner, and as prescribed. It also indicated that medications are administered in accordance with prescriber orders, including any required time frame.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 report to the resident's primary physician the irregularities (includes, but is not limited to, use of medications without adequate indication, without adequate monitoring, in excessive doses, and/or in the presence of adverse consequences, as well as the identification of conditions that may warrant initiation of medication therapy) 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), dated 5/28/2024, for two (2) of five (5) sampled residents (Resident 12 and Resident 61) in accordance with the facility policy. 1. Recommendation to evaluate whether taking Vascazen (helps reduce the risk of heart disease) 1 gram (g, unit of measurement) every night and Vascepa (medicine used to reduce the risk of heart attack, and certain types of heart issues requiring hospitalization in adults with heart disease) 1 g twice a day was indicated for Resident 12. 2. Recommendation to verify the diagnosis and specific target behavior for the use of Zyprexa (medication used to treat certain mental/mood disorders) 10 milligrams (mg, unit of measurement) three times a day for Resident 61. This deficient practice had the potential for Residents 12 and 61 to be administered unnecessary medication, which could result to serious harm. Findings: 1. A review of Resident 12's Admission Record indicated an admission to the facility on [DATE] with diagnoses of heart failure (occurs when the heart muscle doesn't pump blood as well as it should), presence of cardiac pacemaker (a small device used to help your heartbeat at a normal rate and rhythm), and hyperlipidemia (a condition in which there are high levels of fat particles in the blood). A review of Resident 12's Minimum Data Set (MDS, a comprehensive standardized assessment and screening tool), dated 5/21/2024, indicated Resident 12 was moderately impaired (decisions poor, cues/supervision required) with cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decision making. The MDS indicated Resident 12 required supervision with eating and required partial assistance (helper does less than half the effort) with oral hygiene, upper body dressing, and personal hygiene. The MDS indicated Resident 12 required substantial assistance (helper does more than half the effort) with toileting, lower body dressing, and putting on/taking off footwear and was dependent (helper does all the effort) with shower/bathing. A review of Resident 12's Order Summary Report, dated 6/14/2024, indicated the following orders: a. Vascazen oral capsule 1 g, give 1 capsule by mouth at bedtime related to hyperlipidemia, with order date of 2/6/2024. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	b. Vascepa oral capsule 1 g, give 2 capsules by mouth two times a day related to hyperlipidemia, with order date of 3/19/2024. A review of Consultant's Pharmacist's MRR, dated 5/28/2024, indicated a recommendation to evaluate whether taking Vascazen and Vascepa was indicated for Resident 12. 2. A review of Resident 61's Admission Record indicated Resident 61 was originally admitted to the facility on [DATE]. Resident 61's diagnoses included anxiety disorder (persistent and excessive worry that interferes with daily activities), major depressive disorder (depression, is a mood disorder that causes a persistent feeling of sadness and loss of interest), and insomnia (a common sleep disorder that can make it hard to fall asleep or stay asleep). A review of Resident 61's MDS, dated [DATE], indicated Resident 61 was severely impaired with cognitive skills for daily decision making. The MDS indicated Resident 61 required partial assistance with eating, upper body dressing and personal hygiene. It also indicated that Resident 61 required substantial assistance with oral hygiene, lower body dressing and putting on/taking off footwear and was dependent to staff with toileting hygiene and shower. A review of Resident 61's Order Summary Report, dated 5/3/2024, indicated Zyprexa 10 mg tablet by mouth three times daily for mood stabilizer. A review of Consultant's Pharmacist's MRR, dated 5/28/2024, indicated a recommendation to verify the diagnosis for Resident 61's use of Zyprexa 10 mg three times a day and to indicate the behavior manifestation in the physician's order. During an interview with the Director of Nursing (DON) on 6/14/2024 at 4:40 PM, the DON stated that facility did not follow up the MRR for the month of May in timely manner. The DON stated that MRR was done end of May, and she only followed up to the Pharmacist Consultant (PC) on 6/10/2024. The DON stated that recommendations should be reviewed by facility and should have been reported to resident's Doctors if they agree or disagree with the recommendations. The DON stated it was important to act upon the pharmacist recommendation for Resident 12's MRR to evaluate use of Vascazen and Vascepa to make sure that Resident 12 was not taking 2 medications with the same action. The DON also stated it was important to act upon the pharmacist recommendation for Resident 61's MRR to verify the diagnosis for the use of Zyprexa and that the behavior manifestation should be indicated in the order to prevent unnecessary medication. During a concurrent record review of Residents 12 and 61's Pharmacy Consultant's (PC) MRR, dated 5/28/2024, and interview with the PC on 6/14/2024 at 5:35 PM, the PC stated her recommendation for Resident 12 was to make sure resident was not receiving medications with the same effect. PC stated her recommendation was to verify Resident 61's order of Zyprexa to indicate the diagnosis and specific target behavior. (continued on next page)

Printed: 09/27/2024
Form Approved OMB
No. 0938-0391

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	555213	A. Building B. Wing	06/14/2024

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of facility's Policy and Procedure titled, Medication Regimen Reviews, revised in 1/2015, indicated that the primary purpose of the review is to help the facility maintain each resident's highest practicable level of functioning by helping them utilize medications appropriately and prevent or minimize adverse consequences related to medication therapy to the extent possible. It also indicated that the Consultant Pharmacist will provide the Director of Nursing Services and Medical Director with a written, signed, and dated copy of the report, listing the irregularities found and recommendations for their solutions.

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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** 46087 Based on interview, and record review, the facility failed to ensure one (1) of five (5) sampled residents (Resident 61) was free from an unnecessary psychotropic drug (any medication capable of affecting the mind, emotions, and behavior) in accordance with the facility policy and procedure by failing to ensure Resident 61 had a specific target behavior for the use of Zyprexa (medication used to treat certain mental/mood disorders). This deficient practice had the potential to place Resident 61 at risk for significant adverse (harmful) consequences from the use of unnecessary psychotropic drug. Findings: A review of Resident 61's Admission Record indicated Resident 61 was originally admitted to the facility on [DATE]. Resident 61's diagnoses included anxiety disorder (persistent and excessive worry that interferes with daily activities), major depressive disorder (depression, is a mood disorder that causes a persistent feeling of sadness and loss of interest), and insomnia (a common sleep disorder that can make it hard to fall asleep or stay asleep). A review of Resident 61's Minimum Data Set (MDS, a comprehensive assessment and care-screening tool), dated 5/16/2024, indicated Resident 61 was severely impaired with cognitive skills [ability to think, understand, and reason]) for daily decision making. The MDS indicated Resident 61 required partial assistance (helper does less than half the effort) with eating, upper body dressing and personal hygiene. It also indicated that Resident 61 required substantial assistance (helper does more than half the effort) with oral hygiene, lower body dressing and putting on/taking off footwear. Resident 61 was dependent to staff with toileting hygiene and shower. A review of Resident 61's Order Summary Report, dated 5/3/2024, indicated Zyprexa 10 milligrams (mg, unit of measurement) tablet by mouth three times daily for mood stabilizer. A review of Consultant's Pharmacist's Medication Regimen Review, dated 5/28/2024, indicated a recommendation to verify the diagnosis for Resident 61's use of Zyprexa 10 mg three times a day and to indicate the behavior manifestation in the physician's order. During a concurrent record review of Resident 61's medication report and interview with Registered Nurse 1 (RN1) on 6/14/2024 at 2:44 PM, RN 1 stated the Zyprexa originally ordered on 5/3/2024 was incomplete because it did not include the specific diagnosis and specific target behavior it was indicated for. RN 1 stated it was important to include the specific target behavior so the licensed nurses would know what behavior to monitor and to be tallied by hashmark. RN 1 added antipsychotic medication needs monitoring of specific target behavior so the facility would know if the medication was effective or not. RN 1 stated Resident 61's order of Zyprexa for mood stabilizer should have been clarified when it was ordered on 5/3/2024. RN 1 added, The licensed nurses should have monitored Resident 61's behavior, tally by hashmarks to monitor the effectiveness of Zyprexa and the need for medication adjustment if necessary. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent record review of Resident 61's Consultant's Pharmacist's MRR, dated 5/28/2024, and interview with the Pharmacist Consultant (PC) on 6/14/2024 at 5:30 PM, the PC stated Resident 61's Zyprexa order should have been indicated for anxiety manifested with a specific behavior Resident 61 was experiencing such as getting out of bed or screaming. The PC added, behavior monitoring and tally by hashmarks should have been ordered for Resident 61's use of Zyprexa to check the effectiveness of the medication. The PC stated Resident 61 was not and should have been monitored for specific behavior for resident's use of Zyprexa since 5/3/2024 until present (6/14/2024). The PC stated that an order of Zyprexa for mood stabilizer was incomplete because it did not indicate Resident 61's diagnosis. A review of facility's Policy and Procedure titled, The use of psychotropic medication, revised in 6/2013, policy indicated Physicians and mid-level providers such as Psychiatrists (a medical doctor who specializes in mental health) will use psychotropic medications appropriately working with the interdisciplinary team to ensure appropriate use, evaluation, and monitoring. Procedure indicated that orders for psychotropic medication only for the treatment of specific medical and/ or psychiatric conditions or when the medication meets the needs of the resident to alleviate significant distress for the resident not met by the use of non-pharmacologic approaches. Procedure also indicated to document rationale and diagnosis for use and identifies target symptoms.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46087 Cross reference: F755 Based on observation, interview, and record review, the facility failed to ensure that its medication error rate was less than five (5) percent (%). There were seven (7) medication errors out of 25 total opportunities for error, to yield an overall medication error rate of 28 % for one (1) of seven (7) residents observed for medication administration (Residents 50). The medication errors were as follows: 1. During a Medication Pass observation, Licensed Vocational Nurse 1 (LVN 1) failed to administer Dexamethasone (medication that provides relief for inflamed areas of the body) two milligrams (mg, unit of measurement) tablet timely as ordered on 6/14/2024. 2. During a Medication Pass observation, LVN 1 failed to administer the following 9 AM due medications on 6/14/2024: a. Cozaar (medication to lower blood pressure) oral tablet 50 mg b. Lasix (medication to treat fluid retention and swelling) oral tablet 20 mg c. Norvasc (medication to lower blood pressure) oral tablet 5 mg d. Docusate Sodium (stool softener) oral Capsule 100 mg e. Levetiracetam (medication to treat seizures [a sudden, uncontrolled burst of electrical activity in the brain]) oral tablet 750 mg f. Lidocaine Patch 4 percent (medication, a patch to relieve pain) These deficient practices had the potential to result in Resident 50 to experience medication adverse effects (unwanted, uncomfortable, or dangerous effects that a medication may have) and the potential to result in Residents health and well-being to be negatively impacted. Findings: A review of Resident 50's Admission Record indicated the resident was admitted to the facility on [DATE] with diagnosis including angioneurotic edema (unpredictable frequent edematous episodes of cutaneous and mucosal tissues such as lips, eyes, oral cavity, larynx, and gastrointestinal system), hypertension (high blood pressure), and seizures. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the Minimum Data Set (MDS, a standardized assessment and care-screening tool), dated 2/27/2024, indicated Resident 50 had intact cognitive skills (mental action or process of acquiring knowledge and understanding) in decision making. The MDS indicated Resident 50 required partial/moderate assistance (Helper does less than half the effort) from staff with eating. It also indicated Resident 50 was dependent from staff with oral hygiene, toileting, shower, upper and lower body dressing, putting on/taking off footwear and personal hygiene. During a concurrent observation of medication administration and interview with LVN 1 on 6/14/2024 at 8:56 AM, LVN 1 was observed preparing the following medications for Resident 50: 1. Dexamethasone 2 mg tablet 2. Eliquis 5 mg tablet (prevents blood clots) 3. Senna 8.6 mg tablet, two tablets (for constipation) 4. Magnesium Citrate (used to treat constipation) 200 mg, half a tablet 5. Gabapentin (used to treat nerve pain) 300 mg capsule, one capsule LVN 1 stated there were five total morning medications to administer for Resident 50. During an observation on 6/14/2024 at 9:18 AM, in Resident 50's room, Resident 50 was observed taking the five medications by mouth with yogurt and fluids. During a concurrent record review of Resident 50's Order Summary Report (a summary of all currently active physician orders) and interview on 6/14/2024 at 10:55 AM, LVN 1 stated he failed to administer the following: 1. Cozaar oral tablet 50 mg, give 1 tablet by mouth one time a day for hypertension. Hold if systolic blood pressure (SBP, the top number in a blood pressure reading) is less than120. With order date of 6/6/2024. 2. Lasix oral tablet 20 mg, give 1 tablet by mouth one time a day for edema. Hold if SBP is less than 110. With order date of 6/7/2024. 3. Norvasc oral tablet 5 mg, give 1 tablet by mouth one time a day for hypertension. Hold if SBP is less than 110. With order date of 6/6/2024. 4. Docusate Sodium oral capsule 100 mg. Give 1 capsule by mouth two times a day for bowel management, hold for loose stool. With order date of 6/7/2024. 5. Levetiracetam oral tablet 750 mg. Give 2 tablet by mouth two times a day for Seizures. With order date of 6/6/2024. 6. Lidocaine patch 4 percent for pain. Apply to right hip topically (used on the outside of the body) every 12 hours. With order date of 6/7/2024. (continued on next page)

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

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F 0759

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

LVN 1 stated, If medications were not administered on time, for example blood pressure medications, it can affect the blood pressure of the residents which can cause a change in the residents' condition. LVN 1 confirmed that the order of dexamethasone oral tablet 2 mg, to give 1 tablet by mouth every eight (8) hours related to malignant neoplasm (abnormal cells grow, multiply and spread to other parts of your body) of brain, with order date of 6/6/2024, was given at 9:18 AM and per physician's order, it should be given at 2 PM. Medication Administration Record indicated the 6 AM dose was given.

During an interview with Registered Nurse 1 (RN 1) on 6/14/2024 at 2:30 PM, RN 1 confirmed LVN 1 did not administer all of Resident 50's medication. RN 1 stated LVN 1 administered Resident 50's dexamethasone at a wrong time. RN 1 added that dexamethasone administration time was scheduled at 6 AM, 2 PM and 10 PM. RN 1 stated that missed blood pressure medications might lead to uncontrolled high blood pressure. RN 1 stated that a resident who was not given Levetiracetam might have a seizure. RN 1 stated that it was important to administer medication as ordered to get the full benefit of the medication and to prevent complications of inconsistent timing of medication administration.

A review of the facility`s Policy and Procedure (P&P) titled, Policy and Procedure in Medication Administration, revised in 7/2013, indicated all medications will be administered following the scheduled medication administration for routine medication unless otherwise specified by the Doctor which is different from the routine medication administration schedule.

A review of the facility`s P&P titled, Administering Medications, revised in 4/24/2024, indicated a policy that medications are administered in a safe and timely manner, and as prescribed. It also indicated that medications are administered in accordance with prescriber orders, including any required time frame.

A review of the facility's undated Policy and Procedure titled, Job Description and Performance Standards, it indicated primary functions and responsibilities of charge nurse is to administer and document direct resident care, medications and treatments per physician's order and accurately record all care provided.

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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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46087 Based on observation, interview, and record review the facility failed to follow its Medication Storage policy by failing to: 1. Remove a box of expired eye gel from medication storage room [ROOM NUMBER] (MSR 1). 2. Remove a box of expired eye drops from MSR 1 This deficient practice increased the risk for Residents on insulin to receive medication that had become ineffective or toxic due to improper storage possibly leading to health complications, which may result to harm and hospitalization . 3. Store four (4) unopened Basaglar Kwik Pen (a medication used to control high blood sugar) in the refrigerator. 4. Store 4 unopened Trulicity (a medication used to lower blood sugar) in the refrigerator. This deficient practice caused the residents to be exposed to adverse side effects of using expired eye gel and eye drops such as signs of an allergic reaction, like rash, itching, severe dizziness, trouble breathing and blindness if it was used. 5. Defrost (become free of accumulated ice) Refrigerator 1. This deficient practice had the potential to affect the temperature quality of Refrigerator 1 which might affect the efficacy of the refrigerated medications for the residents. Findings: During a concurrent observation in the MSR 1 and interview with Licensed Vocational Nurse 1 (LVN 1) on [DATE] at 12 PM, LVN 1 verified that an opened box of Refresh (brand of an eye lubricant, used for temporary relief of burning, irritation, and discomfort) lubricating eye gel with 20 single use containers were expired in February 2024. LVN 1 also verified that another box of unopened eye drops was also expired, with expiration date of [DATE]. LVN 1 stated the eyedrops should have been removed from MSR 1 when they expired. LVN 1 stated that storing expired supplies increase the risk to be mistakenly used and can cause possible harm to the residents. During a concurrent observation of Medication Cart 2 (MC 2) and interview with LVN 2 on [DATE] at 12:24 PM in Nursing Station 2 (NS 1), 4 unopened Basaglar Kwik Pen and 4 unopened Trulicity were found in the plastic bag on the bottom drawer of MC 2 at room temperature. LVN 2 stated 4 unopened Basaglar Kwik Pen and 4 unopened Trulicity should have been stored in the refrigerator. LVN 2 stated according to the product labeling, unopened), 4 unopened Basaglar Kwik Pen and 4 unopened Trulicity should be stored in the refrigerator. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview with the Director of Nursing (DON) on [DATE] at 1 PM, the DON stated that using expired eye gel, eye drops, and supplies might not be beneficial and could cause harm to the residents. The DON stated the 4 unopened Basaglar Kwik Pen and 4 unopened Trulicity were considered expired and were not safe to administer to the residents since they were not stored in the refrigerator and the DON cannot determine when they were stored at room temperature. The DON stated insulin that was not stored properly could be ineffective at controlling the resident's blood sugar which could cause medical complication to the residents leading to harm and hospitalization . The DON stated that medication refrigerators should be defrosted and cleaned weekly. The DON stated, I don't know when the refrigerator was cleaned and defrosted by licensed nurses since there was no log. During a concurrent observation of Refrigerator 1 and interview with Registered Nurse 2 (RN 2) on [DATE] at 12:13 PM, RN 2 stated that half of the freezer space was accumulated with built up ice. RN 2 stated the refrigerator should have been defrosted because it can impact the temperature quality of refrigerator. RN 2 stated, It might damage and cause problem with preservation of efficacy of the stored refrigerated medication for the residents. RN 2 was unable to provide documented evidence when was the last time Refrigerator 1 was defrosted. A review of facility's Policy and Procedure (P&P) titled, Labeling and Storing Medications, revised in [DATE], indicated the resident's medication will be properly labeled and stored in the locked medication room/carts. It also indicated medications requiring refrigeration will be stored in the refrigerator at the appropriate temperature. Weekly defrosting and cleaning of the refrigerator to be done by 11 PM to 7 AM shift every Friday. Drugs required to be stored at room temperature shall be stored at a temperature between 15 degrees Celsius (C, unit of measurement), 59 degrees Fahrenheit (F, unit of measurement) and 30 degrees C, 86 degrees F. Drugs requiring refrigeration shall be stored in a refrigerator between 2 degrees C and 36 degrees F and 8 degrees C and 46 degrees F. And Medications no longer in use or medications which have expired will be disposed of in accordance with Federal and State Laws.

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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 0810 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide special eating equipment and utensils for residents who need them and appropriate assistance. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46087 Based on observation, interview, and record review, the facility failed to ensure one of 23 sampled resident (Resident 22) who required adaptive feeding equipment (modified utensils, accessories, glasses, and plates to help improve residents' comfort and independence) utilize a plate guard (unique spill guard which prevents food from accidentally being pushed off the plate) during meal, as indicated on the physician's order. This deficient practice placed Resident 22 at risk for further decline in physical functioning and decline to perform self-feeding skills. Findings: A review of Resident 22's Admission Record indicated the resident was admitted to the facility on [DATE] and readmitted on [DATE], with diagnoses including but not limited to aphasia (loss of ability to understand or express speech, caused by brain damage) following cerebral infarction (stroke, a loss of blood flow to part of the brain), dementia (impaired ability to remember, think, or make decisions that interferes with doing everyday activities), hemiplegia (paralysis of one side of the body) and hemiparesis (muscle weakness or partial paralysis on one side of the body that can affect the arms, legs, and facial muscles) affecting right dominant side. A review of Resident 22's Minimum Data Set (MDS, a resident assessment and care screening tool), dated 5/1/2024, indicated Resident 22's cognitive (ability to think and reason) skills for daily decision making was severely impaired. The MDS indicated Resident 22 required partial/moderate assistance (helper does less than half the effort) with eating. It also indicated Resident 22 required substantial/maximal assistance (helper does more than half the effort) with oral hygiene, toileting, upper body dressing, and personal hygiene. Resident 22 was dependent to staff with shower, lower body dressing and putting on/taking off footwear. A review of the Resident 22's Order Summary Report, dated 6/14/2024, indicated the following Physician's Order for kitchen to provide: Plastisol coated big grips spoon for resident to perform self-feeding task, ordered on 2/14/2024. Divided section plate for resident to perform self-feeding task. A review of Resident 22's Care Plan titled, At risk for further decline in activities of daily living (ADLs), revised on 1/17/2024, indicated staff intervention to encourage to continue participating in performing ADLs within his capability including but not limited to washing face, combing hair, feeding self. raising arm during care, dressing, and bathing. During a lunch observation in the dining room on 6/11/2024 at 12:35 PM, Resident 22 was eating lunch with his left hand, without using the utensils that were on the resident's tray. Resident 22's meal tray was observed to have a plate guard and weighted utensils (spoon, fork, and knife). (continued on next page)

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F 0810 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a lunch observation in the dining room on 6/12/2024 at 12:34 PM, Resident 22 was eating lunch without using the weighted spoon. that was on the resident's tray. Resident 22's meal tray was observed to have a plate guard and weighted utensils (spoon, fork, and knife) which were placed on the right side of the resident's plate. During a concurrent observation in the dining room and interview with Director of Rehabilitation (DOR) on 6/13/2024 at 12:40 PM, Resident 22's meal tray was observed to have a plate guard and weighted utensils (spoon, fork, and knife). Resident 22 was eating a bowl of dessert using his left hand and not the weighted utensil that was provided. DOR stated that Resident 22 has right side weakness, and only able to move with his left hand. DOR verified that Resident 22 was eating with his hand, and the weighted utensils were set up on the right side of the plate. DOR stated that utensils should have been placed where Resident 22 could easily reach them, which was on his left side. DOR stated Resident 22 should be checked periodically during meals to make sure that he was eating properly and using the spoon and plate guard. During an interview on 6/14/2024 at 11:25 AM, Treatment Nurse (TN) stated that Resident 22 was able to feed himself using his left hand only because he has right sided weakness. TN stated Resident 22 should be reminded and redirected during mealtimes to use the weighted utensils and utilize the plate guard. During an interview on 6/14/2024 at 1:57 PM, Registered Nurse 1 (RN 1) stated Resident 22 requires assistance with feeding, wherein staff should set up the plate, drinks, utensils. RN 2 stated the staff should provide instructions and ensure for the resident to use the weighted spoon while eating. RN 1 also stated staff should remind the resident to use the spoon if he goes back on using his hand. RN 1 stated assistive devices are to aid residents with eating and utensils should be placed on the resident's strongest side. RN 1 stated this will ensure resident will have an easier access to the assistive devices, be able to properly eat, promote independence, and prevent weight loss. During a concurrent record review of Resident 22's medical records and interview with DOR on 6/14/2024 at 3:20 PM, DOR stated Resident 22 did not and should have a care plan on the use of assistive devices/ weighted utensils and plate guard. A review of facility's Policy and Procedure titled, Assistive Eating Devices, revised on 12/2014, indicated assistive eating devices will be provided for those residents for whom it would be beneficial.

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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 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** 44636 Based on observation, interview, and record review, the facility failed to follow proper food handling practices in accordance with its policy and procedure by failing to: a. Label foods in the kitchen with item 'use by' date (the last date recommended for the use of the product) or open date. b. Discard expired food in the kitchen. c. Store dishes in the kitchen in a sanitary manner. d. Ensure water filter line had an air gap and did not touch the drain on the floor. e. Ensure plunger was stored in accordance with professional standards. These deficient practices had the potential to result in pathogen (germ) exposure to residents and placed 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 a concurrent observation in the kitchen and interview with the Dietary Supervisor (DS) on [DATE] at 8:36 AM, the following were observed: a. resident's personal container with a used napkin on top of the Beef Base seasoning b. opened and undated [NAME] spray. DS stated the resident's dishes were not supposed to be on the shelf with the food seasoning. The DS stated the [NAME] spray was opened but was not and should have been labeled with the open or use by date. The DS stated when an item is opened, staff were supposed to date it with open and use by date. During a concurrent observation in the dry storage of the kitchen and interview on [DATE] at 8:40 AM with the DS, an opened pack of bread was observed on the shelf. The DS stated the bread was not and should have been dated with open and used by date. During a concurrent observation in the kitchen and interview on [DATE] at 8:46 AM with the DS, the following were observed: a. a bowl on the floor under the dish washing machine. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	b. water line filter touched the drain on the floor and went inside the floor drain (plumbing fixture installed in the floor designed to direct water to a sewer or municipal storm drain so floor stays dry, and rooms do not flood). c. bathroom plunger under the receiving station next to the dish washing machine. The DS stated dishes should not be kept on the floor since it was unsanitary. The DS stated the water line filter should not touch or go inside the drain on the kitchen floor. The DS she was unaware there was a plunger in the kitchen and stated the plunger was not supposed to be inside the kitchen. During a concurrent observation in the kitchen's refrigerator and interview on [DATE] at 8:55 AM with the DS, turkey was placed inside a clear container with use by date [DATE]. The DS stated the turkey was expired and should have been discarded. During an interview on [DATE] at 9:01 AM with the DS, the DS stated the resident's personal container containing a used napkin was not supposed to be stored with clean kitchen seasoning supplies. The DS stated improper storage could result in cross contamination (the transfer of harmful substances or disease-causing microorganisms to food by hands, food contact surfaces, sponges, cloth towels, or utensils which are not cleaned after touching raw food, and then touch ready-to-eat foods) and infection especially since the resident's container had a used napkin inside. The DS stated food items were supposed to be discarded after use by date to avoid serving to residents which could result in food poisoning. The DS stated used dishes should be placed in the dirty sink area and not placed on the floor to avoid contamination. The DS stated the water filter line that entered and touched the drain could be contaminated and could also result in backflow (dirty water flowing back into a clean water supply line) into the water system. The DS also stated the plunger could also cause cross contamination. The DS stated she did not know if the plunger was used prior. The DS stated plungers were usually used in the bathroom to unclog the toilet. A review of the facility's Policy and Procedure (P&P) titled, Labeling and Dating of Foods, dated 2020, indicated newly opened food items will need to be closed and labeled with an open date and used by date. A review of the facility's P&P titled, Storage of Food and Supplies, dated 2020, indicated food and supplies will be stored properly and in a safe manner. The policy indicated items and other cleaning supplies should be store in entirely separate and specific areas. The policy also indicated no food will be kept longer than the expiration date on the product. A review of the facility's P&P titled, Refrigerators and Freezers, revised ,d+[DATE], indicated use by dated will be completed with expiration dates on all prepared food in refrigerators. Supervisors will be responsible for ensuring food items in pantry, refrigerators, and freezers are not expired or past perish dates. A review of the facility's P&P titled, Accident Prevention - Safety Precautions, revised ,d+[DATE], indicated if a connection exists between the system and a source of contaminated water during times of negative pressure, contaminated water may be drawn into and foul the entire system. An air gap between the water supply inlet (drainpipe) and the flood level rim of the plumbing fixture (floor sink drain), equipment or non-food equipment shall be at least twice the diameter of the water supply inlet and may not be less than one inch.

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F 0813

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

Have a policy regarding use and storage of foods brought to residents by family and other visitors.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 44636

Based on observation, interview, and record review, the facility failed to follow its policy to monitor the refrigerator and freezer's temperature containing residents' food brought from home to ensure that it was within acceptable temperatures for four of five sampled residents (Residents 18, 31, 47, and 50).

This deficient practice had the potential to result in food-borne illnesses (food poisoning) with symptoms including upset stomach, stomach cramps, nausea, vomiting, diarrhea and fever, other serious medical complications, and hospitalization .

Findings:

A review of Resident 18's Admission Record indicated Resident 18 was initially admitted to the facility on [DATE] and readmitted on [DATE], with diagnoses of malignant (cancerous) neoplasm (abnormal growth of cells in the body) of unspecified site of right female breast.

A review of Resident 31's Admission Record indicated Resident 31 was initially admitted to the facility on [DATE], with diagnosis of Type 2 Diabetes Mellitus (a disease that occurs when there is a problem in the way the body regulates and uses sugar as fuel) with hyperglycemia (high blood sugar).

A review of Resident 47's Admission Record indicated Resident 47 was initially admitted to the facility on [DATE] and readmitted on [DATE], with diagnoses of urinary tract infection (UTI, an infection of the bladder and urinary system) and Type 2 Diabetes Mellitus with hyperglycemia.

A review of Resident 51's Admission Record indicated Resident 51 was initially admitted to the facility on [DATE], with diagnoses of hemiplegia (a condition caused by brain damage or spinal cord injury that leads to paralysis [loss of motor function in one or more muscles] on one side of the body) and hemiparesis (weakness on one side of the body) following cerebral infarction (a stroke, damage to tissue in the brain due to loss of oxygen to the area) affecting the left non-dominant side.

During on observation on 6/11/2024 at 11:59 AM of the facility's residents' refrigerator, a log titled, Break Room dated 6/2024 was posted in front of the refrigerator door. The sign indicated the refrigerator's temperature should be at of 35 degrees ( ) Fahrenheit (F) to 40 for refrigerators and 0 F or less for freezers. The log included the date, recorded by, time, temperature for the refrigerator and freezer, and comments section to be completed by staff. The staff's first name or initials were entered in the log for 7 AM from 6/1/2024 to 6/11/2024, but the section for temperature of the refrigerator and freezer, and comments sections were left blank.

During the same observation on 6/11/2024 at 11:59 AM of the facility's residents' refrigerator and freezer, an undated signage titled, Refrigerator Temperature Guide, indicated as follows:

-Above 40 : Any temperature above 40 F may allow bacteria to multiply rapidly.

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F 0813 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-At 40 : The U.S. Food and Drug Administration (FDA, responsible for protecting the public health by ensuring the safety of the nation's food supply and assumes primary responsibility for preventing foodborne illness) indicated the recommended refrigerator temperature is below 40 F. -Between 35 and 38 : The ideal refrigerator temperature is between 35 F, below the safety threshold outlined by the FDA and above freezing. It's not uncommon for refrigerators to be a few degrees off the mark you set, so err on the side of too cold to avoid food spoiling more quickly or potential food safety issues. -At 32 : At 32 F and below, the food in your refrigerator will start to freeze. Keep your refrigerator temperature above 32 F to avoid this, and if you want anything frozen, put it in the freezer, which should be kept below 0 F. During a concurrent observation and interview on 6/13/2024 at 2:39 PM with the Dietary Supervisor (DS), the DS stated the housekeepers were in charge of checking the residents' food items in the residents' refrigerator. The DS stated the housekeeper did not record any temperatures for the refrigerator or freezer from 6/1/2024 to 6/11/2024. The DS stated the monitoring of temperatures ensured the residents' foods were stored at a safe temperature. The DS stated the residents' refrigerator and freezer contained resident food items brought by residents' families and visitors. The DS stated the current refrigerator temperature was at 50 F. The DS stated the residents' refrigerator temperature was in the danger zone since the temperature was above 40 F. The DS stated it was unsafe for the residents to consume food stored at 50 F. The DS stated food kept at a temperature of 50 F could cause food poisoning to the residents. A review of the facility's Policy and Procedure titled, Refrigerators and Freezers, revised 4/2024, indicated monthly tracking sheets for all refrigerators and freezers will be posted to record temperatures. Food service supervisors or designated employees will check and record refrigerator and freezer temperatures daily. Acceptable temperatures should be 35 F to 41 F for refrigerators.

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F 0848 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide a neutral and fair arbitration process and agree to arbitrator and venue. 48152 Based on interview and record review, facility failed to ensure the arbitration agreement (a contract in which the right to bring certain claims to court for resolution is given up) included for the selection of a venue that is convenient (a location in which to carry out arbitration proceedings which should be agreed upon and suitable to both parties (facility and residents) for two of three sampled residents (Resident 3 and 21). This failure resulted in violation of Residents 3 and 21's right to be informed of all information related to an arbitration agreement. Findings: A review of an Arbitration Agreement signed by Resident 3 on 3/25/2019, failed to indicate information to address the selection of a venue convenient to both parties. A review of an Arbitration Agreement signed by Resident 21 on 5/29/2024, failed to indicate information to address the selection of a venue convenient to both parties. During a concurrent record review of the facility's Resident - Facility Arbitration Agreement and interview on 6/13/2024 at 11:48 AM with the Admissions Coordinator (AC), AC stated the agreement failed to indicate any mentions or providence of a convenient location for any arbitrations. The AC stated the agreement does not indicate the selection of a convenient venue to use for arbitrations. The AC stated her role was to present the arbitration agreement to residents (or family) and only present what was listed on the arbitration agreement when explaining it to the residents (or family). The AC stated she does not make mention of the selection of a venue that is convenient to both parties. AC stated she does not know when residents would be made aware of the right to a convenient location to be used for arbitration.

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

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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 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46087 Based on interview and record review, the facility failed to ensure a coordination of care between the facility and hospice (care designed to give supportive care to people in the final phase of a terminal illness and focus on comfort and quality of life, rather than cure) staff for three of three sampled residents (Residents 61, 52, and 64) in accordance with the facility's hospice policy and hospice agreement by failing to ensure: 1. Hospice staff visited Resident 61 per Hospice calendar. 2. and 3. Residents 52 and 64 had a hospice comprehensive assessment to include the frequency of hospice staff visits This deficient practice had the potential for Resident's 61, 52, and 64 not to receive the hospice care and services necessary to promote comfort and quality of life. Findings: 1. A review of Resident 61's Admission Record indicated Resident 61 was originally admitted to the facility on [DATE]. Resident 61's diagnoses included end stage heart failure (heart's inability to pump an adequate supply of blood), hypertension (chronic elevated blood pressure), and seizures (sudden, uncontrolled electrical disturbance in the brain which can cause changes in behavior, movements, feelings, and consciousness). A review of Resident 61's Minimum Data Set (MDS, a comprehensive assessment and care-screening tool), dated 5/16/2024, indicated Resident 61 was severely impaired with cognitive skills [ability to think, understand, and reason]) for daily decision making. The MDS indicated Resident 61 required partial assistance (helper does less than half the effort) with eating, upper body dressing and personal hygiene. It also indicated that Resident 61 required substantial assistance (helper does more than half the effort) with oral hygiene, lower body dressing and putting on/taking off footwear. Resident 61 was dependent to staff with toileting hygiene and shower. A review of Resident 61's Order Summary Report, dated 6/14/02024, indicated Resident 61 was under hospice, ordered on 5/3/2024. A review of Resident 61's Hospice Care Plan, initiated on 5/3/2024, indicated a goal that Resident 61's choice for desired level of care will be honored daily. Interventions were as follows: Certified Home Health Aide (CHHA) visits twice a week, initiated on 5/3/2024 and revised on 5/6/2024. Hospice Nurse visits twice a week, initiated on 5/3/2024 and revised on 5/6/2024. Social Worker visit one to two times a month, initiated on 5/3/2024 and revised on 5/6/2024. (continued on next page)

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Pastoral counseling visit, frequency of visit was left blank, initiated on 5/3/2024. A review of Resident 61's hospice binder indicated the following: a. Hospice plan of care (POC, a written care plan established, maintained, reviewed and revised as necessary, to intervals established by the Hospice Interdisciplinary Team [Hospice employees]) summary dated 5/10/2024, indicated hospice staff nurse frequency of visit of twice a week with a start date of 5/14/2024, hospice CHHA visit frequency of once a week after admission and twice a week on succeeding weeks for Activity of Daily Living (ADL's) and personal care with start date of 4/27/2024, hospice social worker frequency of once a month and as needed with start date of 4/27/2024. b. Hospice calendar of visit starting 5/5/2024 to 6/7/2024 indicated that there should be five (5) hospice Registered Nurse (RN) visits, eight (8) hospice Licensed Vocational Nurse (LVN) visits, 10 hospice CHHA visits, and one (1) hospice staff visit for spiritual support, prayers, and counseling. c. Patient Calendar for the month of May 2024 indicated 12 signatures from hospice staff. d. Hospice flow sheet from 5/5/2024 to 6/6/2024 indicated 14 hospice staff visits. During a concurrent record review of Resident 61's hospice binder and interview with Hospice LVN (HLVN) on 6/14/2024 at 10 AM, HLVN stated that resident on hospice has their hospice binder, which contains all the Resident's hospice records. HLVN stated that having a hospice binder was important for the facility staff because it was where they check hospice nurses' visits and documentation. HLVN stated they communicate with the facility staff and would document resident visit under flow sheet. HLVN stated that hospice CHHA has no documentation of visits, nor a signature from hospice CHHA was documented in the patient calendar. HLVN added hospice CHHA visit should be documented for the facility to know which ADL's and hygiene was provided to Resident 61. HLVN stated that they are required to document in hospice flow sheet regarding their visit. HLVN added that all hospice staff including Doctor, Nurse Practitioner, RN, LVN, CHHA, Social worker, and Pastor should document in the hospice flow sheet and patient calendar. During a concurrent record review of Resident 61's hospice binder and interview with Registered Nurse 1 (RN 1) on 6/14/2024 at 2:50 PM, RN 1 stated hospice calendar of visit starting 5/5/2024 to 6/7/2024 indicated that there should be 5 hospice RN visits, 8 hospice LVN visits, 10 hospice CHHA visits, and 1 hospice staff visit for spiritual support, prayers, and counseling. RN 1 stated that there should have been total of 24 hospice staff visits from 5/5/2024 to 6/7/2024. RN 1 confirmed that not all hospice staff that was indicated in the hospice calendar from 5/5/2024 to 6/7/2024 has a documentation in the hospice flow sheet and resident calendar. RN 1 stated that facility staff has no documentation in electronic nurse's notes whenever hospice staff visited in the past. RN 1 stated that hospice staff should communicate with the facility staff when they plan to visit or have visited a resident. RN1 stated that hospice flow sheet was important so facility would know what hospice staff did during their visit to Resident 61. RN 1 stated that hospice binder has the Hospice plan of care summary that indicated hospice staff nurse frequency of visit of twice a week, hospice CHHA visit frequency of once a week after admission and twice a week on succeeding weeks for ADL's and personal care, and hospice social worker frequency of once a month and as needed. RN 1 stated the frequency of hospice staff visits was not reflected on the hospice flow sheet, and not the same to the hospice care plan on resident's facility chart. (continued on next page)

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of facility's Policy and Procedure (P&P) titled, Hospice, revised in 4/2024, indicated the facility shall maintain documentation in the patient's health record that will demonstrate the patient terminal status and the coordination of hospice service to the patient by the interdisciplinary team (IDT). The hospice staff is an integral part of the facility's IDT. It also indicated the various Hospice staff shall wire progress notes and entries during each visit to the patient. A review of the Hospice Agreement dated 5/3/2024, duties and obligations of the facility indicated facility and Hospice shall prepare and maintain complete medical records for Hospice Clients receiving facility services in accordance with this agreement and shall include all treatments, progress note, authorizations, Physician orders and other patient's information. Copies of all documents of services provided by Hospice at Hospice office, Facility and Hospice shall each have access to the Hospice Client's records maintained by the other party for verification of patient care and financial information pertinent to the Agreement. Access to Hospice Clients' records shall be provided during routine hours of business and each party shall give reasonable notice to the other of its intent to review such records. It also indicated duties and obligations of Hospice to maintain a complete and timely clinical record on each Hospice Client relating to all service rendered. Alt records of service and treatment are part of the Hospice record. 44636 2. A review of the Resident 52's Admission Record indicated Resident 52 was admitted to the facility on [DATE], with diagnoses of schizoaffective disorder (a mental illness that causes loss of contact with reality) bipolar type (mental disorder characterized by episodes of mania [extreme highs] and depression [extreme lows]), anxiety disorder (persistent and excessive worry that interferes with daily activities), and hemiplegia (a condition caused by brain damage or spinal cord injury that leads to paralysis [loss of motor function in one or more muscles] on one side of the body) and hemiparesis (weakness on one side of the body) following cerebral infarction (a stroke, damage to tissue in the brain due to loss of oxygen to the area) affecting the left non-dominant side. A review of the MDS, dated [DATE], indicated Resident 52's cognitive patterns were intact. The MDS indicated Resident 52 had an impairment in the upper extremity (shoulder, elbow, wrist, hand) and an impairment in the lower extremity (hip, knee, ankle, foot). The MDS indicated Resident 52 was dependent (helper does all of the effort, resident does none of the effort to complete the activity) for oral hygiene, toileting hygiene, shower/bathe self, upper and lower body dressing, putting on/taking off footwear, personal hygiene (combing hair, shaving, washing/drying face and hands), roll left and right, sit to lying, lying to sitting, chair/bed-to-chair transfer, and tub/shower transfer. The MDS also indicated Resident 52 received hospice care. A review of Resident 52's Care Plan, initiated 5/24/2024, indicated Resident 52 was admitted under hospice level of care. The care plan interventions were CHHA visits, hospice nurse visits, and pastoral counseling visit. A review of Resident 52's Physician Order Summary Report, dated 5/24/2024, indicated hospice level of care with terminal diagnosis (medical prognosis illness or condition is not curable and likely to result in death) of cerebral infarction due to unspecified occlusion of stenos of right mid cerebral artery (rare but potentially devastating cause of stroke). A review of Resident 52's Hospice Plan of Care Summary Orders indicated as follows: (continued on next page)

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	555213	A. Building B. Wing	06/14/2024

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- 5/24/2024: Frequency of Visits: Certified Home Health Aide (CHHA) visit one time a week for the first week after admission and two times a week on succeeding weeks for activities of daily living (ADLs) and personal care. - 5/24/2024: Frequency of Visits: Registered Nurse (RN) Supervisory visit. -5/24/2024: Frequency of Visits: Spiritual Counselor (SC) initial and one time a month and three as needed for spiritual support, prayers, and counseling. - 5/25/2024: Frequency of Visits: Skilled Nurse (SN) visits two times a week plus three as needed for change in condition and symptoms management. A review of Resident 52's Hospice Resident Calendar and Flow Sheet, dated 5/24/2024 to 5/31/2024, indicated as follows: - RN (unknown) visit on 5/24/2024, 5/25/2024, and 5/27/2024. - SN (unknown) visit on 5/30/2024. There were no CHHA and SC visits and SN visits conducted two times a week for May 2024. A review of Resident 52's Hospice Resident Calendar and Flow Sheet, dated 6/1/2024 to 6/14/2024, indicated as follows: - SN (unknown) visit on 6/3/2024, 6/6/2024, and 6/14/2024. - RN (unknown) visit on 6/10/2024. - SC (unknown) visit on 6/11/2024. There were no CHHA visits for the month of June 2024. SN visits were not done two times a week, and there was only one RN visit. There was no hospice calendar for staff frequency of visits for the months of May and June 2024. 3. A review of Resident 64's Admission Record indicated Resident 64 was admitted to the facility 5/7/2024, with diagnoses of malignant (cancerous) neoplasm (abnormal growth of cells in the body) of unspecified part of unspecified bronchus (one of the two tubes that carry air into the lungs from the trachea) or lung, pleural effusion (fluid buildup in the space between the lung and the chest wall), and atelectasis (collapse of a lung or part of a lung due to air loss in the air sacs). A review of Resident 64's MDS, dated [DATE], indicated Resident 64's cognitive skills for daily decision making were moderately impaired. The MDS indicated Resident 64 was dependent (helper does all of the effort, resident does none of the effort to complete the activity) for sit to stand and chair/bed-to-chair transfer. The MDS indicated Resident 64 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) for toilet hygiene, shower/bathe self, roll left and right, sit to lying, and lying to sitting on side of bed. The MDS also indicated Resident 64 received hospice care. (continued on next page)

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of Resident 64's Care Plan, initiated 5/7/2024, indicated Resident 64 required comfort care/hospice care. The care plan interventions were Resident 64 was under the hospice care, CHHA visits as ordered, hospice nurse visits, and pastoral counseling visit. A review of Resident 64's Physician Order Summary Report, dated 5/8/2024, indicated admit hospice level of care with terminal diagnosis of malignant neoplasm of unspecified bronchus or lung cancer. A review of Resident 64's Hospice Plan of Care Summary Orders indicated as follows: - 5/7/2024: Frequency of Visits: CHHA two times a week for the first week after admission and two times a week on succeeding weeks for ADLs and personal care. - 5/7/2024: Frequency of Visits: RN Supervisory visit. -5/7/2024: Frequency of Visits: SC initial and one time a month and three as needed for spiritual support, prayers, and counseling. - 5/12/2024: Frequency of Visits: SN visits two times a week plus three as needed for change in condition and symptoms management. A review of Resident 64's Hospice Resident Calendar and Flow Sheet, dated 5/7/2024 to 5/31/2024, indicated as follows: - RN (unknown) visit on 5/7/2024, 5/9/2024, 5/12/2024, 5/16/2024, 5/23/2024, 5/27/2024, and 5/31/2024. - SN (unknown) visit on 5/8/2024, 5/15/2024, and 5/30/2024. There were no CHHA and SC visits and SN visits were not done two times a week for May 2024. A review of Resident 64's Hospice Resident Calendar and Flow Sheet, dated 6/1/2024 to 6/14/2024, indicated as follows: - RN (unknown) visit on 6/5/2024, 6/7/2024, and 6/10/2024. - SN (unknown) visit on 6/3/2024, 6/4/2024, and 6/6/2024. - SC (unknown) visit on 6/11/2024. There were no CHHA visits and SN visits conducted two times a week for the month of June 2024. There was no hospice calendar for staff frequency of visits for the months of May and June 2024. (continued on next page)

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent review of Residents 52 and 64's Hospice Plan of Care Summary Orders an interview on 6/14/2024 at 9:06 AM with RN 2, RN 2 stated the order for Hospice RN did not specify the frequency of RN visits. RN 2 stated RN 2 was unaware of how often hospice RNs were supposed to visit Residents 52 and 64. RN 2 stated RN 2 relied on the hospice calendar to coordinate Residents 52 and 64's care with hospice staff. RN 2 stated hospice usually provide a calendar indicating hospice staff visit frequency and days. RN 2 stated based on the hospice calendar, RN 2 could follow up with hospice if hospice staff were scheduled and did not show up. RN 2 stated RN 2 did not know which hospice staff was scheduled to visit or when the specific hospice staff were supposed to visit Residents 52 and 64. RN 2 stated the importance of having a hospice calendar was to ensure a collaboration of care between hospice and the facility. RN 2 also stated the absence of the hospice calendar could result in Residents 52 and 64's to not receive the care that was supposed to be provided from hospice. During an interview on 6/14/2024 at 9:49 AM with Licensed Vocational Nurse 4 (LVN 4), LVN 4 stated the hospice RN was scheduled to visit every two weeks for stable residents but can come more often when the resident was unstable. During an interview on 6/14/2024 at 3:17 PM with the Director of Nursing (DON), the DON stated the hospice binder was the communication between the hospice staff and facility staff. The DON stated the hospice staff's communication of care was documented in the binder. The DON stated the hospice staff should sign in legibly so the licensed nurses could see who came to visit the hospice resident. The DON stated a hospice calendar should be included in the hospice binder to ensure continuity of care. The DON stated the hospice calendar would show when the CHHA, SN, and RN were scheduled to visit. The DON stated without a hospice calendar, the facility was unaware of the hospice staff schedule. The DON stated if the hospice staff did not visit per schedule and the facility staff were unaware of the hospice schedule and did not follow up this would result in neglect of the hospice residents. A review of the facility's Policy and Procedure titled, Hospice, revised 4/2024, indicated the Hospice Team shall be responsible for providing the following documentation in the patient's health record: the various Hospice staff shall wire progress notes and entries during each visit to the patient. A review of the Hospice and Nursing Facility Services Letter of Agreement, updated 3/24/2023, the agreement indicated Hospice shall assess the individual's need for care and services upon admission and on an ongoing basis. Hospice shall be responsible for the professional management and coordination of the plan of care. Hospice shall collaborate with facility on a coordinated plan of care developed jointly between hospice and facility.

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F 0868 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have the Quality Assessment and Assurance group have the required members and meet at least quarterly 48152 Based on interview and record review, facility failed to conduct a monthly Quality Assessment and Assurance (QAA, process to evaluate activities under the Quality Assurance and Performance Improvement [QAPI, process used to ensure services are meeting quality standards and assuring care reaches a certain level) program, such as identifying issues with respect to which QAA activities, including PI projects required under the QAPI program, are necessary) meeting as indicated in the facility policy and procedure (P&P). This failure had the potential to result in inadequate, incomplete provision of care and services provided to residents throughout the facility, decreasing their quality of life. Findings: During an interview on 6/14/2024 at 5:47 PM with Infection Preventionist Nurse (IPN), IPN stated every department in the facility makes a report to identify what needs to be improved and the QAPI meetings are for all departments to come together to present what areas need to be improved and to discuss solutions that can be implemented after the meeting. IPN stated QAPI has not had consistent monthly meetings but should. IPN stated QAPI improves the care of the residents, which means better quality care with the possibility of better and faster solutions to concerns and residents can be negatively affected by having a slower outcome to solutions. During a concurrent record review and interview on 6/14/2024 at 5:57 PM with the Director of Nursing (DON), the facility's QAPI binder was reviewed. The binder did not have any QAPI meeting conducted for the months of 10/2023, 11/2023, 12/2023, 1/2024, 2/2024, 3/2024, and 5/2024. The DON stated, the most recent QAPI meetings held were on 4/25/2024 and 9/28/2023. The DON stated the purpose of QAPI is to ensure residents receive quality healing care and their needs are being attended to. The DON also stated residents benefit from QAPI meetings because staff can evaluate if the approaches (to resident's care) are effective, and if QAPI meetings are not being done per policy, the residents [health, condition] will decline. A review of the facility P&P titled QAPI, revised 4/24/2024, indicated the facility is to maintain an ongoing, facility- wide, data-driven QAPI program that is focused on indicators of the outcomes of care and quality of life for residents and meetings are to be monthly to review reports, evaluate data and monitor QAPI related activities and make adjustments to the plan.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46919 Based on observation, interview and record review, the facility failed to implement appropriate infection control practices for one of two sampled residents (Resident 62) as indicated on the facility's policy and procedure (P&P) by failing to ensure availability and use of EPA (Environmental Protection Agency) approved disinfectant solution in cleaning a contact isolation (used when a resident has an infectious disease that may be spread by touching either the resident of other objects the resident has handled) room with Clostridium difficile (C. diff- a bacteria that causes diarrhea), This deficient practice placed the residents, staff, and visitors at higher risk for cross-contamination, and increased spread of C. diff infection in the facility and the community. Findings: A review of resident 62's Admission Record indicated Resident 62 was admitted to the facility on [DATE] with diagnoses that included acute (severe and sudden onset) and chronic (long lasting) respiratory failure with hypoxia (a condition where there's not enough oxygen or too much carbon dioxide in the body), enterocolitis (inflammation of both the small intestine and the colon) due to Clostridium difficile not specified as recurrent, and sepsis (infection in the blood). A review of resident 62's Minimum Data Set (MDS, a standardized assessment and care planning tool), dated 5/2/2024, indicated Resident 62 was assessed having moderately impaired (decisions poor; cues/supervision required) cognitive (mental action or process of acquiring knowledge and understanding) skills with daily decision making and was dependent (helper does all of the effort) with eating, toileting hygiene, shower/bathe self, upper/lower body dressing, and personal hygiene. A review of Resident 62's Order Summary Report, dated 6/14/2024, indicated a physician order, with a start date of 6/10/2024, for contact isolation secondary to C. Diff colitis (inflammation of the large intestines). A review of Resident 62's Order Summary Report, dated 6/14/2024, indicated a physician order, with a start date of 6/10/2024 fir Vancomycin HCL (a medication to treat infection) Oral Solution Reconstituted (diluted) 25 milligrams (mg- unit of measurement)/milliliters (ml- unit of measurement), give 10 ml via G-tube (a flexible tube surgically inserted through the wall of the abdomen directly into the stomach for feeding, fluid, and medication administration) four times a day for C. Diff until 6/20/2024 at 11:59 PM. A review of Resident 62's Care Plan, dated 6/10/2024, indicated Resident 62 was on contact isolation precautions related to C. Diff colitis. Resident 62's care plan intervention indicated to implement appropriate isolation techniques by staff, resident, visitors. During a concurrent observation of Resident 62's room and interview with Licensed Vocational Nurse 2 (LVN 2), on 6/11/2024 at 11:37 AM, LVN 2 stated Resident 62 was on contact isolation for C. Diff. LVN 2 stated Resident 62 was currently taking antibiotic (a medicine that inhibits the growth of or destroys microorganisms) for C. Diff. (continued on next page)

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview with Housekeeping 1 (HKP 1), on 6/13/2024, at 3:17 PM, HKP 1 stated she cleaned Resident 62's room last today because it was an isolation room. HKP 1 stated she used Cleaning Solution 1 (CS 1) to clean Resident 62's floor. HKP 1 stated she also used CS 1 to clean the floors in the facility. HKP 1 stated she did not know if CS 1 contained bleach. During an interview with HKP 2, on 6/14/2024, at 9:03 AM, HKP 2 stated Resident 62 was on contact isolation but did not know what type of infection Resident 62 was isolated for. HKP 2 stated she used CS 2 to clean the floor in Resident 62's room. HKP 2 stated Resident 62's room was supposed to be cleaned with bleach (a chemical used to sterilize or disinfect). HKP 2 stated she did not know if CS 2 had bleach. HKP 2 stated the infection can be on the floor and if it is not cleaned with the proper cleaning solution the infection can be spread to other areas in the facility. During an interview with the Infection Preventionist Nurse (IPN), on 6/14/2024, at 10:37 AM, the IPN stated Resident 62 currently had active C. diff. The IPN stated a room isolated for C. diff should only be disinfected with bleach or cleaning solutions listed on the EPA's registered Antimicrobial Products Effective Against Clostridioides difficile (C. diff) Spores [List K] list. The IPN stated that according to the EPA, the cleaning solutions under List K are the only cleaning solutions than can effectively kill C. diff. The IPN stated it is important to use the proper cleaning solution in C. diff rooms to prevent the spread of C. diff to other residents. During an interview with Registered Nurse 1 (RN 1), on 6/14/2024, at 3:41 PM, RN 1 stated Resident 62 was isolated because she had an active C. diff infection. RN 1 stated residents and facility staff can get exposed to C. diff if the room is not cleaned properly with a bleach solution. RN 1 stated residents who get infected with C. diff can get sick and possible transferred to the hospital. During a concurrent interview and record review with the IPN, on 6/14/2024, at 5:18 PM, the IPN stated CS 1 and CS 2 were not included in the EPA's registered Antimicrobial Products Effective Against Clostridioides difficile (C. diff) Spores [List K] list. During the same concurrent interview and record review with the IPN, on 6/14/2024, at 5:18 PM, the manufacturer's guideline for CS 1 and CS 2 were reviewed. The IPN stated CS 1 did not include bleach as an active ingredient. The IPN stated the manufacturer's guideline for CS 1 did not indicate CS 1 was an effective cleaning solution for disinfecting C. diff. The IPN stated the manufacturer's guideline for CS 2 did not indicate CS 2 was an effective cleaning solution for disinfecting C. diff. A review of the facility's P&P, titled, Clostridium Difficile, revised on 4/24/2024, indicated, Measures are taken to prevent the occurrence of Clostridium Difficile infections (CDI) among residents. Precautions are taken while caring for resident with C. Difficile to prevent transmission to other residents. The P&P indicated, Environmental cleaning in rooms of residents with CDI is done with a disinfecting agent recommended for C. difficile (example: household bleach and water solution or an EPA registered germicidal agent effective against C. difficile spores).

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 06/14/2024
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)
F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. 44636 Based on observation and interview, the facility staff failed to provide a safe environment in the kitchen by failing to: 1. Ensure the portable air conditioner unit was safely plugged into the wall outlet. 2. Ensure the wall outlet was free of tape covering the plug and outlet when the generator was plugged into the wall outlet. This deficient practice had the potential to result in a fire which placed residents, staff, and visitors at risk. Findings: During on observation on 6/11/2024 at 8:52 AM in the kitchen, there was a double gang box switch and outlet combo (device that combines a switch and an electrical outlet in the same enclosure box) between the kitchen sink and towel dispenser. The bottom of outlet combo had an extension cable plugged in. The extension cable had a bug zapper, a phone charger, a large black portable air conditioning unit Portacool plugged in (about the height of the sink). Approximately a foot below the double gang box switch and outlet combo was a wall outlet with two outlets. The wall outlet had multiple layers of blue tape covering the bottom outlet and generator plug. The generator's orange cable was observed coming out of the blue tape from the bottom outlet. There was a sign Please do not disconnect cable from wall outlet thank you to the right of the blue tape. During a concurrent observation and interview on 6/11/2024 at 9:22 AM of the outlets in the kitchen with the Maintenance Supervisor (MS), MS stated the black portable air conditioner was not supposed to be connected to the extension cord. The MS stated the extension cord used did not have a safety switch and could catch on fire. The MS stated the portable air conditioner needed to be directly connected to the outlet and not connected to the extension cord. The MS also stated the plug connected to the outlet covered with blue tape could catch on fire and cause a fire in the kitchen. The MS stated the generator had an orange cable which was not supposed to be used for regular outlets, but only for hospital outlets. The MS stated the generator plugged inside the kitchen was located outside of the kitchen. The MS stated the generator was temporarily being used since the facility's generator was being in serviced. The MS stated the facility building could not operate without a generator. A review of the facility's Policy and Procedure (P&P) titled, Accident Prevention - Safety Precautions, revised 4/2024, indicated do not use equipment with frayed or ungrounded cords and plugs. A review of the facility's P&P titled, Maintenance Service, revised 4/2024, indicated the maintenance department was responsible for maintaining equipment in a safe manner at all times. Functions of maintenance personnel include maintaining the building free from hazards.