STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555893	A. Building B. Wing	06/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pasadena Nursing Center	1570 North Fair Oaks Ave 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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** Based on observation, interview and record review, the facility failed to provide pharmaceutical services in accordance with the facility's policies and procedures (P&P) by failing to ensure two (2) licensed nurses witnessed the disposition of discontinued medications and record accurately. This deficient practice had the potential to result in the inability to identify loss of medications and potential for drug diversion (illegal distribution or abuse of prescription medications or their use for unintended purposes).Findings: During a concurrent observation in the medication room and interview with Supervisor (RNS) on [DATE] at 3:18 PM, with the Director of Nursing (DON), RNS was observed sitting alone inside the medication room disposing medications. RNS was observed removing medications from the bubble pack (also known as a blister pack or compliance pack, which is a method of organizing a resident's medications into individual, sealed compartments) and putting them in a blue container without a lid. RNS stated she was disposing of the medications for residents who were no longer in the facility and medications that have been discontinued. The DON stated the medications in the blue bin will be dispensed into the incineration bin (is a secure, specialized disposal container designed to collect expired, unused, or contaminated pharmaceuticals). During a concurrent interview and record review on [DATE] at 10:29 AM with the DON, the medication destruction records dated [DATE] and [DATE], were reviewed. The medication destruction record dated [DATE] indicated the DON signed as the second licensed nurse. The DON stated she signed the medication destruction record dated [DATE] but did not witness the destruction of the medications with the RNS. The medication destruction record, dated [DATE], indicated the list and quantity of medications disposed of and one licensed staff signature. There was no signature of a second licensed nurse as witness. The DON stated Licensed Vocational Nurse (LVN 1) disposed of medications on [DATE] and the signature of a second licensed nurse was missing. The DON stated if there was no second signature, it meant that no other licensed nurse witnessed the medication destruction/disposal. The DON stated the P&P was not followed to have two licensed nurses when disposing medications. The DON also stated During an interview on [DATE] at 10:15 AM with RNS, the RNS stated she was alone in the medication room during the destruction/disposition of the medications. RNS stated there was no second licensed staff that witnessed removal of medications from its packaging and when poured into the incinerator bin. RNS stated that the witness should be present throughout the process. During a concurrent interview and record review on [DATE] at 10:33 AM, the P&P titled, Discarding and Destroying Medications, dated [DATE], was reviewed. The P&P indicated that the medication disposition record contains the signature of witnesses. The DON stated if there was no second signature, it meant that no other licensed nurse witnessed the medication destruction/disposal.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 - Few	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** Based on observation, interview, and record review, the facility failed to follow its policy for discarding and disposing of medications by failing to:Discard one (1) expired Lantus (long acting man-made insulin used to control high blood sugar) injectable pen (portable, easy to use device used by people with diabetes [chronic condition where the body either cannot produce enough insulin or cannot use it properly] to inject insulin) which was stored in Medication Cart 2.Discard two (2) expired glucose control solutions (a liquid with a known amount of sugar used to verify the blood glucose meter [portable electronic device that measures the amount of sugar [glucose] in the blood] and test strips [small, disposable plastic strips coated with chemicals that react with a tiny drop of blood] are working correctly) used to calibrate blood glucose meter which were stored in Medication Carts 1 and 2.This deficient practice had the potential for residents to receive Lantus insulin that had become ineffective, which could affect the residents' diagnosis management of diabetes and using expired glucose control solutions had the potential to result in inaccurate glucometer calibration which can potentially result in erroneous blood sugar readings which could lead to residents experiencing change in condition and hospitalization. Findings: 1. During a concurrent observation and interview on [DATE] at 9:44 AM with Licensed Vocational Nurse 1 (LVN 1) and the Director of Nursing (DON), Medication Cart 2 was observed with 1 Lantus injectable pen labeled with expiration date of [DATE]. LVN 1 and DON stated the expired Lantus injectable pen should have been discarded. The DON and LVN 1 stated that if expired insulin was administered, it could potentially result to residents experiencing adverse effects from receiving expired insulin that could lead to change in conditions and hospitalization. During a concurrent interview and record review on [DATE] at 2:42 PM, the P&P titled. Medication Labeling and Storage, revised [DATE], the DON stated the P&P indicated multidose vials that have been open or accessed are dated and discarded within 28 days unless the manufacturer specifies a shorter or longer date. 2. During a concurrent observation, interview, and record review on [DATE] at 10 AM, the glucose control solutions manufacturer's instructions leaflet (printed document packed with a product that provides the user with essential information on its safe and proper use) was reviewed. The DON and LVN 1 stated the manufacturer's instructions leaflet indicated to use the control solution within 90 days of first opening. The glucometer control solution in Medication cart 1 was labeled with use by date of [DATE]. The glucometer control solution in Medication cart 2 was labeled with open date of [DATE]. The DON and LVN 1 stated that the glucometer control solutions stored in Medication carts 1 and 2 were past the use by dates. The DON and LVN 1 stated using expired control solutions to calibrate glucometers will give inaccurate calibration and potentially affect glucometer readings when checking the blood sugar of residents. During an interview with the DON on [DATE] at 2:42 PM, the DON stated that there was no specific P&P regarding glucometer control solutions, but the facility is to follow the manufacturer's instructions. The DON stated using expired control solutions to calibrate the glucose meters can result in inaccurate calibration that can potentially result in erroneous blood sugar readings for the residents which can also potentially result in hypoglycemia (low blood sugar) or hyperglycemia (high blood sugar) if insulin was given based on blood sugar readings that could lead to change in condition and hospitalization.