

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555893	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/20/2025
NAME OF PROVIDER OR SUPPLIER Pasadena Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Reasonably accommodate the needs and preferences of each resident.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45523</p> <p>Based on observation, interview, and record review, the facility failed to ensure that the call light (a device used by residents to call for assistance) was placed within reach (an arm's length) for two of 17 sampled residents (Resident 11 and Resident 37).</p> <p>This deficient practice had the potential to result in delayed provision of services and care and assistance with activities of daily living (ADLs- refers to basic self-care tasks that are necessary for maintaining daily life) which could result in harm to Residents 11 and 17.</p> <p>Findings:</p> <p>1. During a review of the Admission Record, the Admission Record indicated Resident 11 was initially admitted to the facility on [DATE] and re admitted on [DATE] with diagnoses that included but not limited to type 2 diabetes mellitus (a disease in which your blood glucose, or blood sugar, levels are too high), unspecified dementia (a term used to describe a group of symptoms affecting memory, thinking and social abilities), and bipolar disorder (extreme mood swings that include mania [emotional highs] and depression [mood disorder that causes a persistent feeling of sadness and loss of interest] which may lead to impaired functioning).</p> <p>During a review of Resident 11's Minimum Data Set (MDS, a resident assessment tool), dated 1/27/2025, the MDS indicated Resident 11 was severely impaired in cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decision making. Resident 11 needed substantial assistance (helper does more than half the effort) from the staff for activities of daily living such as eating and upper body dressing and was total dependent (helper does all of the effort) for oral and toilet hygiene, shower, and lower body dressing.</p> <p>During a record review of Resident 11's Care Plan, initiated on 2/26/2024 and revised on 12/13/2024, the Care Plan indicated Resident 11 was moderate risk for falls related to gait/balance problems and weakness. The Care Plan interventions indicated to ensure the resident's call light was within reach and to encourage the resident to use it (call light) for assistance as needed. The Care Plan indicated Resident 11 required prompt response to all requests for assistance and required a safe environment. The Care Plan indicated Resident 11 required a working and reachable call light.</p> <p>(continued on next page)</p>

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an observation on 3/17/2025 at 9:28 AM in Resident 11's room, Resident 11 was observed in bed sleeping. A soft touch call light (a type of call light that activates when lightly touched, rather than requiring a firm press, making it easier for residents with limited dexterity or mobility to signal for help) was observed placed on the top left side of Resident 11's head of bed not within Resident 11's reach.</p> <p>During a concurrent observation and interview on 3/19/2025 at 10:56 AM, with Certified Nurse Assistant 2 (CNA2), Resident 11's call light was observed. CNA 2 stated Resident 11's call light was not within reach since it was placed on the upper left side by Resident 11's shoulder. CNA 2 stated Resident 11 could not reach for the call light.</p> <p>During a concurrent observation and interview on 3/19/2025 at 10:59 AM, with CNA 2, Resident 11 was observed. CNA 2 stated Resident 11 call light should be placed within Resident 11's reach. CNA 2 was observed handing Resident 11 the call light, but Resident 11 could not reach or extend his hand to grab the call light. CNA 2 stated Resident 11 was unable to use the call light to call for help since the call light was not within reach. CNA 2 stated since Resident 11 could not reach the call light, Resident 11 could fall since sometimes he slides off the bed and this could definitely cause a potential harm to him such as an injury. CNA2 stated, the CNAs know to place the call lights within reach for a patient. I don't know why his call light was so far away from him, it was placed behind his head on the other side of the bed, it was too high.</p> <p>During an interview with CNA 3 on 3/19/2025 at 11:07 AM, CNA 3 stated, the resident has a Touch call light because he is not able to use a regular call light due to his arms and hands being contracted at times. CAN 3 stated, the call light has to be on top of him so he can touch it easily and call for help. CNA 3 stated Resident 11 there was no way Resident 11 could call for assistance since the call light was not placed within Resident 11's reach.</p> <p>During an observation inside Resident 11's room on 3/19/2025 at 11:09 AM, Resident 11 was observed unintentionally pressing the call light more than one time. After staff came into check in Resident 11, Resident 11 stated not needing any assistance. CNA 3 was observed placing the call light on Resident 11's chest and stated, sometimes when a resident has a sensitive call light, they accidentally call multiple times and maybe that's why the call light had been placed away from him.</p> <p>During an interview with CNA 4 on 3/19/2024 at 11:12 AM, CNA 4 stated that the residents call light needs to be next to the pillows, pinned on pillowcase, close to patient where the residents can reach it and call in case they need to. CNA 4 stated, when a resident could not reach or use the call light, we must check the residents every 5 to 10 mins and check to see if they are ok. CNA 4 stated we must continue to go in and check on them, we are not supposed to be ignoring a patient no matter how many times they call. CNA 4 stated call lights should not be removed or placed away from the resident even if the resident presses the call light multiple times.</p> <p>(continued on next page)</p>		

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<p>F 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview with License Vocational Nurse (LVN) 1 on 3/19/2025 at 11:15 AM, LVN1 stated, Call lights need to be within reach of the residents. The residents that can't move have a sensitive call light it's more of a touch and it's very sensitive for easier use. If a resident keeps on using the call light to call us, then we must keep checking on them, and the staff are aware they are not allowed to move the call light away from the resident, it must be within reach for any emergency because it can potentially be harmful to the patient and it's not acceptable. LVN 1 stated the call light should not be above the residents' shoulder, since that was too high for Resident 11 to reach. LVN 1 stated the call light should not be hanging from the head of bed away from the resident, it must be visible to the resident and within the residents' reach.</p> <p>During an interview with the Director of Nursing (DON) on 3/19/2025 at 11:16 AM, the DON stated, the residents call light should always be within reach. It is not appropriate for the call light to be placed away from the resident, especially if it's a touch sensitive call light. The resident cannot call for help or assistance.</p> <p>48903</p> <p>2. During a review of Resident 37's Admission Record, the Admission Record indicated Resident 37 was admitted to the facility on [DATE] with diagnosis that included fracture (break in bone) of right femur (long bone of leg), schizoaffective disorder (a mental illness that can affect thoughts, mood, and behavior) and bipolar disorder.</p> <p>During a review of Resident 37's MDS, dated [DATE], the MDS indicated the resident was assessed to have moderately impaired cognition (capable of remembering, learning new things, concentrating, or making decisions that affect everyday life) and required partial/moderate assistance (helper does less than half the effort) for toileting. The MDS indicated Resident 37 required supervision (helper provides verbal cues or touching assistance) for oral hygiene, showering, upper/lower body dressing and putting on/taking off footwear and set up or clean up assistance (helper sets up or cleans up) for eating.</p> <p>During a concurrent observation and interview on 3/17/2025 at 10:20 AM with Certified Nursing Assistant1 (CNA1), Resident 37's call light was observed clipped to a light pull string behind Resident 37's bed. CNA 1 stated, The call light is not in reach of the resident (Resident 37). It's important to have the call light in reach so the resident can call for help if he has a medical emergency like a heart attack (a blockage of blood flow to the heart muscle) and can get help.</p> <p>During a concurrent interview and record review on 3/20/2025 at 8:48 AM with the Director of Nursing (DON), the facility's P & P titled, Answering the Call Light, dated 3/2021 was reviewed. The P & P indicated the purpose of the P&P was to ensure timely response to the resident's requests and needs. The P&P indicated when the resident is in bed to be sure the call light is within easy reach of the resident. The DON stated, The call light should be within the reach of the resident because that is the only way they can call for help. The DON stated a resident's condition could worsen since the resident could not reach the call light to call for assistance such as if they cannot breathe. The DON stated Resident 37's call light was not within reach because it was tied to a light pull string behind Resident 37's bed. The DON stated the policy indicated the call light should be easily reached.</p> <p>(continued on next page)</p>		

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During review of the facility's Policy and Procedure (P&P) titled Answering the Call Light revised 3/2021, indicated, the purpose of the P&P was to ensure timely responses to the residents' request and needs. The P&P general guidelines indicated when the resident is in bed or confined to a chair be sure the call light is within easy reach of the resident and that Some residents may not be able to use their call light. The P&P indicated to be sure you check these residents frequently.		

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<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46087</p> <p>Based on observation, interview and record review, the facility failed to inform the physician (MD) of a change in condition (any noticeable deviation from a patient's baseline or expected state of health, requiring prompt assessment and intervention) for one (1) of five (5) sampled residents in accordance with the facility's policy and procedure (P&P) titled, Change in a Resident's Condition or Status, after Resident 152 exhibited increased aggression and physically assaulted certified nurse assistant 5 (CNA5) on 3/18/25.</p> <p>This deficient practice had the potential to result in a delay of care and services, which could negatively affect Residents 152's overall wellbeing.</p> <p>Findings:</p> <p>During a review of Resident 152's Admission Record, the Admission Record indicated Resident 152 was admitted to the facility on [DATE] with diagnoses of schizoaffective disorder (a mental illness that can affect thoughts, mood, and behavior), anxiety (a group of mental health conditions that cause excessive fear and worry), and hallucinations (seeing, hearing, smelling, tasting, or feeling that seem real but are not).</p> <p>During a review of Resident 152's History and Physical (H & P) dated 3/13/2025, the H & P indicated Resident 152 is not competent to understand his/her medical condition and patient's bill of rights, therefore the staff is instructed to present this information to a family member, guardian, or conservator.</p> <p>During a review of Resident 152's situation, background, assessment, recommendation record (SBAR, a communication tool used by healthcare workers when there is a change of condition among the residents), dated 3/18/2025, timed at 3:35 AM and written by Licensed Vocational Nurse 3 (LVN 3), the SBAR indicated at 1:30 AM Resident 152 came out of his room and suddenly attack CNA 5 and hit CNA 5 on the left side of his face without apparent reason. The SBAR indicated Charge nurse (LVN 4) went to CNA 5 and approached Resident 152 in calm manner to stop Resident 152 from further hurting CNA 5. The SBAR indicated Resident 152 was very agitated, physically aggressive and cursing and yelling at staff. The SBAR indicated Haldol (medication to treat nervous, emotional, and mental condition) 5 milligrams (mg, unit of measurement) intramuscular (IM, a medical procedure where a medication is injected directly into a muscle) was administered as needed (PRN) to subdue Resident 152's aggression.</p> <p>During an observation on 3/18/2025 at 8 AM, Resident 152 was observed pacing the hallway.</p> <p>During an interview on 3/20/2025 at 6:50 AM with LVN 3, LVN 3 stated Resident 152 had a change of condition on 3/18/2025 around 1 AM. LVN 3 stated LVN 4 was the licensed nurse (LN) assigned to Resident 152, and that LVN 4 was the one who administered the PRN Haldol to Resident 152 after being physically aggressive towards CNA 5. LVN 3 stated documenting on Resident 152's SBAR but did not inform Resident 152's MD regarding Resident 152's change of condition related to physical aggression.</p> <p>(continued on next page)</p>		

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<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a concurrent interview and record review on 3/20/2025 at 6:54 AM with LVN 4, Resident 152's medical records were reviewed. LVN 4 stated that on 3/18/2025, after 1 AM, Resident 152 became physically aggressive and punched (strike with the fist) CNA 5 on the left side of the face, after asking to smoke outside of the facility. LVN 4 stated PRN Haldol was administered to Resident 152 and stated this was the first time that Resident 152 became aggressive to staff and punched a CNA. LVN 4 stated not informing Resident 152's MD regarding this change of condition and physical aggression towards staff, however there was not documented evidence indicating the MD was informed. LVN 4 stated for any change in condition, such as physical aggression from a resident, the MD must be informed to prevent a recurrence of the incident and potential new physician orders to control behaviors</p> <p>During a concurrent observation and interview on 3/20/2025 at 7:10 AM with CNA 5, CNA 5 was observed with left face swelling and redness. CNA 5 stated Resident 152 punched him (closed fist) on 3/18/2025.</p> <p>During a review of Facility's P&P titled, Change in a Resident's Condition or Status, revised February 2021, indicated facility promptly notifies the resident, his or her attending physician, and the resident representative of changes in the resident's medical/mental condition and/or status. The P&P also indicated the nurse will notify the resident's attending physician or physician on call when there has been a(an) accident or incident involving the resident and/or significant change in the resident's physical/emotional/mental condition.</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45523</p> <p>Based on observation, interview, and record review, the facility failed to ensure germicidal disposable wipes (disinfectant wipes designed to kill a wide range of microorganisms [a living thing that is so small it must be viewed with a microscope] on hard, non-porous surfaces [examples of hard nonporous surfaces include stainless steel, metal, glass, hard plastic, and varnished wood] and not intended to be used on the resident's skin) were not used to sanitize one of 17 sampled residents' (Resident 17) hands prior to providing nail care.</p> <p>This deficient practice had the potential to result in skin irritation and harm to Resident 11.</p> <p>Findings:</p> <p>During a review of the Admission Record, the admission record indicated Resident 11 was initially admitted to the facility on [DATE] and re admitted on [DATE] with diagnoses that included but not limited to type 2 diabetes mellitus (a disease in which your blood glucose, or blood sugar, levels are too high), unspecified dementia (a term used to describe a group of symptoms affecting memory, thinking and social abilities), and bipolar disorder (mood disorder that causes intense shifts in mood, energy levels and behavior).</p> <p>During a review of Resident 11's Minimum Data Set (MDS, a resident assessment tool), dated 1/27/2025, indicated Resident 11 was severely impaired with cognitive skills (mental action or process of acquiring knowledge and understanding) for daily decision making. Resident 11 needed substantial assistance (helper does more than half the effort) to dependence with the staff for activities of daily living.</p> <p>During a review of Resident 11's Care Plan initiated 2/26/2024 indicated Resident 11 has an ADL self-care performance decline & reduced mobility and is dependent on staff for all aspects of ADLs. Staff interventions indicated for staff to monitor and provide ADL assistance to extent necessary to meet needs, to keep him clean and well-groomed daily.</p> <p>During a concurrent observation and interview with CNA4 on 3/19/2025 at 11:27 AM, CNA4 stated that he was assigned to cut the residents fingernails on that day, which included Resident 11. CNA4 stated, I use the purple wipes to disinfect the residents' hands before I clip their nails, then I disinfect the clipper with the same purple wipes. Observed CNA4 walk over to the purple top container of wipes hanging from the hallway wall, pointed and confirmed that the wipes he used on the residents' hands was the germicidal disposable wipes.</p> <p>During an observation and interview with Director of Nursing (DON) on 3/19/2025 at 11:32 AM, the DON stated according to the picture/ instruction on the germicidal disposable wipes container, it should not be used on residents skin because it can cause harm to the residents since they have fragile skin. The DON stated, The staff can use it to sanitize equipment only not on residents' skin, it can potentially cause harm if the residents have sensitive skin.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview with Infection Prevention Nurse (IPN) on 3/19/25 at 12:48 PM, IPN stated that germicidal wipes are used for disinfecting areas, surfaces, medical shared equipment, and the nursing stations. Per IPN, germicidal wipes are not supposed to use on skin or to disinfect the residents' hands. Per IPN, the staff should use the preferred method of hand washing or use the hand sanitizers in the facility. IPN stated, We have the spectrum advanced hand sanitizer container if they are not able to wash their hands. It's not acceptable to use germicidal wipes on residents' hands because it can make them susceptible for skin breakdown as indicated on the container.</p> <p>During a concurrent interview with IPN on 3/19/2025 at 1:00 PM, IPN stated, The CNAs know they are supposed to wash the residents' hands with soap and water not use the germicidal wipes before they can clip their nails.</p> <p>During an interview with Director of Staff Development (DSD) on 3/19/25 at 1:04 PM, DSD stated that germicidal wipes are used for disinfecting surfaces that have been touch. Per DSD, the staff should not use germicidal wipes on residents' hands. DSD stated the label of the germicidal wipes container indicated not to use on skin or as baby wipes. DSD stated germicidal wipes should not be used on any resident's skin because the elderly population can be prone to skin reaction if it's used on them.</p> <p>During a review of the facility's policy titled, Care of Fingernail/Toenails, revised 2/2018, indicated that the purposes of this procedure are to clean the nail bed, to keep nails trimmed, and to prevent infections.</p> <p>Steps in the procedure:</p> <ol style="list-style-type: none"> 3. Fill the wash basin one-half full of warm soapy water. 4. Allow first hand or foot to soak in the warm soapy water for approximately five (5) minutes. Encourage the resident to exercise his or her fingers or toes while they are soaking. 6. Rinse the hand or foot that has been in the soapy water with clear, warm water. 7. Dry the hand or foot with a towel. 12. Do not trim nails below the skin line or cut the skin 		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide appropriate pressure ulcer care and prevent new ulcers from developing.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45523</p> <p>Based on observation, interview, and record review, the facility failed to ensure the low air loss mattress (LALM- a specialized medical mattress designed to prevent and treat pressure ulcer [wound that occurs as a result of prolonged pressure on a specific area of the body]) by maintaining a cool, dry environment through constant airflow, which helps regulate temperature and moisture) was on the correct setting for two (2) of 2 sampled residents (Resident 11 and Resident 29) in accordance with the physician's orders and LALM operator's manual instructions.</p> <p>This deficient practice placed Residents 11 and 29 at risk of poor wound healing and deterioration (something once in good condition is now weakened, worn out, or otherwise in decline) of current pressure ulcers.</p> <p>Findings:</p> <p>1. During a review of the Admission Record, the admission record indicated Resident 11 was initially admitted to the facility on [DATE] and re admitted on [DATE] with diagnoses that included but not limited to type 2 diabetes mellitus (a disease in which your blood glucose, or blood sugar, levels are too high) unspecified protein calorie malnutrition (a disorder caused by a lack of proper nutrition or an inability to absorb nutrients from food), unspecified dementia (a term used to describe a group of symptoms affecting memory, thinking and social abilities), schizoaffective disorder , bipolar type (combines symptoms of both schizophrenia [like hallucinations and delusions] other lack of coordination (a medical condition, often called ataxia, characterized by a loss of muscle coordination, leading to clumsy or jerky movements, unsteady gait, and difficulty with balance and fine motor skills), and unspecified atrial fibrillation (a condition where the upper chambers of the heartbeat irregularly and rapidly).</p> <p>During a review of Resident 11's physician's orders, dated 1/25/2025, the physician's orders indicated May have LALM to be set at 202 pounds (lbs., unit of mass) every shift for wound management with one layer over mattress.</p> <p>During a review of Resident 11's Minimum Data Set (MDS- a resident assessment tool), dated 1/27/2025, the MDS indicated Resident 11 was severely impaired in cognitive skills (mental action or process of acquiring knowledge and understanding) for daily decision making. Resident 11 needed substantial assistance (helper does more than half the effort) from the staff for the activities of daily living such as eating and upper body dressing and was total dependent (helper does all of the effort) for oral and toilet hygiene, shower, and lower body dressing.</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a review of Resident 11's Weekly Wound Observation Tool (a record used to track the progress and characteristics of a wound over time, typically assessed and documented every week, to monitor healing and identify any potential issues or changes), dated 2/18/2025, the tool indicated Resident 11 is on LALM as a special equipment for preventable measure due to left heel having a diabetic/ ischemic (a condition where there is an inadequate blood supply to a specific tissue or organ) and wound tissue being unstable and purple with wound measurements of length 2 centimeters (cm, units of measure), width 0.5cm, depth unstageable, full thickness skin or tissue loss - Depth Unknown (UTD- indicates a wound where the true depth cannot be determined due to the presence of slough [dead tissue that is usually yellow, tan, gray, or green in color, usually moist and stringy in texture, that may be found in wounds] or eschar [dead tissue that is hard or soft in texture; usually black, brown, or tan in color, and may appear scab-like, usually firmly attached to the base, sides and/or edges of the wound and over time falls off] obscuring the wound bed).</p> <p>During a review of Resident 11's Care Plan initiated on 2/26/2025, the care plan indicated Resident 11 is incontinent (unable to control the excretion of urine or the contents of the bowels) with bowel and bladder elimination. Staff interventions indicated were to assess/record/monitor wound healing and to use low air loss mattress due to resident requiring the bed as flat as possible to reduce sheer (minimizing the forces that cause tissues to slide or move in opposite directions, which can lead to skin damage and pressure ulcers, particularly in individuals with limited mobility).</p> <p>During a review of Resident 11's weight, resident's weight indicated the following:</p> <p>3/7/2025 -190 lbs.</p> <p>2/7/2025 - 188 lbs.</p> <p>During observation in Resident 11's room on 3/17/2025 at 9:21 AM, observed Resident 11 resting in bed with LALM setting at 280 lbs.</p> <p>During a concurrent observation in Resident 11's room on 3/19/2025 at 10:58 AM, observed Resident 11 resting in bed with LALM setting at 190 lbs.</p> <p>During an interview with Certified Nursing Assistant 2 (CNA2) on 3/19/2025 at 11:59 AM, CNA2 stated, The setting of the bed was set at 190 lbs. The bed settings are done by the charge nurse, treatment nurse or supervisor. As a CNA, if the settings of the bed are off or the machine starts beeping, we call the nurse to come and fix it.</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>2. During a review of the Admission Record, the admission record indicated Resident 29 was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included but not limited to unspecified protein calorie malnutrition (a disorder caused by a lack of proper nutrition or an inability to absorb nutrients from food), encounter for attention to gastrostomy (a medical visit or procedure focused on the care, maintenance, or management of a gastrostomy tube [G-tube-an artificial opening in the stomach used for feeding or medication delivery]), edema (swelling or puffiness caused by an excessive accumulation of fluid in the body's tissues), unspecified soft tissue disorder related to use, overuse and pressure multiple sites (conditions affecting muscles, tendons, ligaments, and other soft tissues due to repetitive movements, excessive strain, or pressure, often occurring in multiple areas of the body), and pressure ulcer of unspecified heel and stage (the medical provider or clinician cannot determine the depth or stage of the ulcer due to a lack of documentation or because the ulcer is covered by eschar or slough).</p> <p>During a review of Resident 29's physician's orders, dated 11/31/2025, timed at 9:59 AM, indicated, May have LALM with settings at 129 lbs. monitor functioning well, every shift for wound management.</p> <p>During a review of Resident 29's MDS, dated [DATE], indicated Resident 29 was severely impaired with cognitive skills for daily decision making. Resident 29 needed substantial assistance from the staff for the activities of daily living such as eating, oral hygiene and upper body dressing and was total dependent for toilet hygiene, shower, and lower body dressing.</p> <p>During a review of Resident 29's weight, the resident's weight indicated the following:</p> <p>2/7/2025 - 136 lbs.</p> <p>3/7/2025 -128 lbs.</p> <p>During a review of Resident 29's Braden scale for predicting pressure sore risk (a tool used in healthcare to assess a resident's risk of developing pressure ulcers by evaluating six factors: sensory perception, moisture, activity, mobility, nutrition, and friction/shear), dated 2/20/2025, timed at 8:03 PM, indicated Resident 29 was at high risk for pressure sores due to a score of 10.</p> <p>During a review of Resident 29's Interdisciplinary Team (IDT- a group of professionals from different disciplines who collaborate to achieve a common goal, leveraging their diverse expertise and perspectives to solve complex problems or address multifaceted issues) meeting, dated 3/19/2025, indicated Resident 29 has bilateral (pertaining to both sides) heels wound, right arm discoloration, back of right shoulder discoloration, and edema on both lower legs.</p> <p>During observation in Resident 29's room on 3/17/2025 at 9:21 AM, observed Resident 29 resting in bed with LALM setting at approximately 300 lbs.</p> <p>During observation in Resident 29's room on 3/18/2025 at 7:21 AM, observed Resident 29 resting in bed with LALM setting at 160 lbs.</p> <p>During observation in Resident 29's room on 3/19/2025 at 11:09 AM, observed Resident 29 resting in bed with LALM setting at 150 lbs.</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview with CNA3 on 3/19/2025 at 11 AM, CNA3 confirmed Resident 29's LALM setting was set at 150 lbs. CNA3 stated the CNAs don't touch the settings for the LALM because that responsibility falls on the licensed nurses since the reason for the LALM is to help reduce the pressure on the resident's skin and prevent a pressure sore causing the resident harm.</p> <p>During an interview with Licensed Vocational Nurse 1 (LVN1) on 3/19/2025 at 11:15 AM, LVN1 stated, LAL mattress settings are set by the treatment nurse, but the charge nurses check it too. We know how to place the settings because it's according to the resident's weight. LVN3 stated, the LALM setting is set according to the physician's order. LVN 3 added that the LALM setting should be based on the resident's weight. LVN1 stated not setting the LALM correctly according to the directions or physician's orders will not help the residents' wounds or skin condition since the LALM was to prevent skin damage or relieve pressure from the resident's skin.</p> <p>During an interview with LVN2 on 3/19/2025 at 9:52 AM, LVN2 stated the LALM should be set as indicated on the doctors' orders and/ resident's weight. LVN2 stated, If the settings are off, the LALM may not have enough pressure relief and that will cause more harm than good to the resident. It doesn't help the resident to have a hard mattress, that can cause skin breakdown, and it can be a potential for infection, especially if the resident is incontinent. The whole use for the LALM is to prevent any further damage to the patient's skin. That is why we must follow the doctors order which is to set the settings to the resident's weight.</p> <p>During a review of the facility's Policy and Procedure (P&P) titled, Support Surface Guidelines, revised 9/2013, the P&P indicated, The purpose of this procedure is to provide guidelines for the assessment of appropriate pressure reducing and relieving devices for residents at risk of skin breakdown.</p> <p>During a review of the Operator's Manual for the facilities pressure low air mattress system for operating instructions, the manual indicated to determine the resident's weight and set the control knob to that weight setting on the control unit.</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>49537</p> <p>Based on interview and record review, the facility failed to prevent the elopement (a form of unsupervised wandering that leads to the resident leaving the facility) for one of two residents (Resident 252) assessed as at risk for elopement by failing to implement the facility's Wandering and Elopement Policy and Procedures (P&P) by failing to:</p> <ol style="list-style-type: none"> 1. Develop a care plan to ensure Resident 252 received interventions to prevent elopement when assessed as elopement risk on 11/4/2024. 2. Have documented evidence of Resident 252's family and physician notification when resident eloped and was found on 11/16/2025. 3. Have documented evidence that Resident 252 was examined for injuries upon return on 11/16/2025 and have the relevant information documented in the resident's medical record. <p>This deficient practice resulted in Resident 252 eloping from the facility on 11/16/2024 which placed the resident at risk for exposure to extreme weather, medical complications, injury, serious harm, and/or death.</p> <p>Findings:</p> <p>During a review of Resident 252's Admission Record, the Admission Record indicated the facility admitted Resident 252 on 11/4/2024 with diagnoses that included but not limited to dementia with psychotic disturbance (also known as dementia-related psychosis, occurs when individuals with dementia [a loss of memory, language, problem-solving and other thinking abilities that are severe enough to interfere with daily life] experience delusions[believing someone is trying to harm them] or hallucinations [false sensory perceptions]), hypertension (when the blood pressure, [the force of blood flowing through the blood vessels], is consistently too high), generalized muscle weakness (widespread feeling of weakness or loss of muscle strength in multiple areas of the body), and unsteadiness on feet (walking in an abnormal, uncoordinated, or unsteady manner).</p> <p>During a review of Resident 252's Minimum Data Set (MDS-a resident assessment tool), dated 11/11/2024, the MDS indicated Resident 252 had intact cognitive skills (mental action or process of acquiring knowledge and understanding through thought, experience and the senses) for daily decision making. The MDS indicated Resident 252 required set up or clean up assistance (Helper sets up or cleans up, resident completes the activity. Helper assists only prior to or following the activity) with eating and oral hygiene. The MDS indicated Resident 252 required supervision or touching assistance (Helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity. Assistance may be provided throughout the activity or intermittently with upper body dressing, walking 10 feet (ft-unit for measuring length) and walking 50 ft with two turns and required partial/moderate assistance (Helper lifts, holds, or supports trunk or limbs, but provides less than half the effort) with walking 10 ft on uneven surfaces.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a concurrent interview and record review on 3/20/2025 at 9:03 AM with the Director of Nursing (DON), the Admission Assessment for elopement risk dated 11/4/2024 and care plan were reviewed. The Admission Assessment for elopement risk indicated Resident 252 was at risk for elopement. The DON stated there was no care plan for elopement in Resident 252's medical record initiated on 11/4/2024 when the resident was assessed as at risk for elopement. The DON stated it was important to initiate the elopement care plan immediately after conducting the elopement risk assessment so the staff would know what interventions to do to prevent resident from eloping such as how frequent the resident should be monitored, documenting resident's behavior of wandering and looking for exits, and notifying the MD and family representative if elopement occurs. The DON stated that if the care plan was initiated as soon as elopement risk was identified, the incident could have been prevented. The DON also stated that she was not aware of any elopement incident for Resident 252 on 11/16/2024 because she was off duty that day.</p> <p>During a concurrent interview and record review on 3/20/2025 at 9:25 AM with the DON, the Progress notes for Resident 252 were reviewed. There was no documentation of Resident 252's elopement incident on 11/16/2025. The DON stated any elopement incidents should be documented in the resident's medical record.</p> <p>During an interview on 3/20/2025 at 10:30 AM with MDS Nurse (MDSN), the MDSN stated the care plan for at risk for wandering/elopement should have been initiated on 11/4/2024 when Resident 252's was identified as at risk for wandering/elopement. The MDSN stated she does not know why the care plan was only initiated on 11/18/2024. The MDSN stated that care plans are initiated so all staff are aware and should implement interventions to prevent of elopement.</p> <p>During a phone interview on 3/20/2025 at 11:04 AM with Licensed Vocational Nurse 3 (LVN 3), LVN 3 stated she was on duty on 11/16/2024 from 7AM to 3PM and she recalled Resident 252 went missing that day (11/16/2024). LVN 3 stated she called the police department and when the police officer arrived at the facility, the police officer called Resident 252's family representative (Family 1) to inquire any contact with the resident. LVN 3 stated Resident 252 was found later that day (11/16/2024) and was brought back to the facility by the police officer. LVN 3 stated according to Family 1, Resident 252 had called Family 1 using a bystander's phone to let them know she was lost and where she was. Family 1 had called the police to inform them where Resident 252 can be found. LVN 3 stated that the Administrator was informed by Registered Nurse Supervisor (RN 1) of Resident 252's elopement incident on 11/16/2024. LVN 3 stated Administrator came to the facility and reviewed the video surveillance with her, the police, and RN 1. LVN 3 stated through the video surveillance, it was determined Resident 252 used the staff elevator and exited through the facility entrance door. LVN 3 stated RN 1 documented the elopement incident in Resident 252's medical records.</p> <p>During an interview on 3/20/2025 at 12:53 PM with Medical Records Director (MRD), the MRD stated she could not find any documentation regarding Resident 252 eloping on 11/16/2024. MRD stated that Resident 252 was being monitored for elopement since admission but no documentation in the medical records that Resident 252 did elope. MRD also stated that there was no Situation, Background, Assessment, and Recommendation (SBAR- a communication tool used by healthcare workers when there is a change of condition among the residents) regarding the elopement incident for Resident 252, no resident assessment upon return, or family and physician notification of the elopement found in Resident 252's medical record.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a concurrent interview and record review on 3/20/2025 at 1:13 PM with the Infection Prevention Nurse (IPN), Resident 252's Progress notes were reviewed. There was no documentation of elopement incident on 11/16/2024.</p> <p>During a phone interview on 3/20/2025 at 3:25 PM with Family 1, Family 1 stated Police Officer 1 had called her and left a voice message around 9 AM to 9:20 AM notifying her that they were called by the nursing facility to help search for Resident 252 and to call the Police dispatch if the resident called her. Family 1 stated she was driving to the facility when she received a call from Resident 252 using Bystander's phone saying she was lost. Family 1 spoke with Bystander 1 and requested her to stay with the resident until a police officer picked her up to be brought back to the nursing facility. Family 1 stated Bystander was walking around Recreation Park 1 when Resident 252 approached her around 10:15 AM stating she was lost and if she could use her phone to call Family 1. Family 1 stated she then called the Police Dispatch to notify them where to find Resident 252. Family 1 stated nursing facility staff did not notify her that Resident 252 went missing, and it was the Police officer who provided the information.</p> <p>During a review of the facility's P&P titled, Wandering and Elopements, revised March 2019, the P&P indicated the facility will identify residents who are at risk of unsafe wandering and strive to prevent harm while maintaining the least restrictive environment for residents. The P&P also indicated:</p> <ol style="list-style-type: none"> 1. If identified as at risk for wandering, elopement, or other safety issues, the resident's care plan will include strategies and interventions to maintain the resident's safety. 2. If a resident is missing, initiate the elopement/missing resident emergency procedure: if the resident was not authorized to leave, initiate a search of the building(s) and premises; and if the resident is not located, notify the Administrator and the DON, resident's legal representative, the attending physician, law enforcement officials. 3. When the resident returns to the facility, the DON or charge nurse shall: examine the resident for injuries; contact attending physician and report findings and condition of the resident; notify resident's legal representative; complete and file an incident report and document relevant information in the resident's medical record. <p>During a review of the facility's P&P titled, Accidents and Incidents - Investigating and Reporting, revised July 2017, the P&P indicated:</p> <ol style="list-style-type: none"> 1. The nurse supervisor/charge nurse and/or the department director or supervisor shall promptly initiate and document investigation of the incident. 2. The following data, as applicable, shall be included on the Report or Incident/Accident Form: date and time the incident took place; the circumstances surrounding the incident; the names of witnesses and their accounts of the incident; the date and time the attending physician and family were notified; disposition of the resident; any corrective action taken; follow up information; and the signature and title of the person completing the report. 		

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<p>F 0693</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48903</p> <p>Based on observation, interview and record review the facility failed to administer the correct gastrostomy tube (g-tube, tube inserted through the belly that brings nutrition directly to the stomach) formula feeding as ordered by the physician (MD) for one (1) of two (2) sampled residents (Resident 102) in accordance with the facility's policy and procedure (P&P) titled, Enteral Tube Feeding via Continuous Pump.</p> <p>This deficient practice had the potential to cause Resident 102 to have uncontrolled blood sugar, and inappropriate nutrition and worsening of Resident 102's health condition.</p> <p>Findings:</p> <p>During a review of Resident 102's Admission Record, the Admission Record indicated Resident 102 was admitted to the facility on [DATE] with diagnosis that included: type two (2) Diabetes (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing), dysphagia (difficulty swallowing), schizophrenia (a mental illness that is characterized by disturbances in thought) and shortness of breath.</p> <p>During a review of Resident 102's history and physical (H&P) dated 8/20/2024, the H&P indicated Resident 102 was able to understand his medical condition.</p> <p>During a review of Resident 102's Minimum Data Set (MDS; a resident assessment tool) dated 1/20/2025, the MDS indicated the resident had intact cognition (capable of remembering, learning new things, concentrating, or making decisions that affect everyday life) and required set up or clean up assistance (helper sets up or cleans up) for eating. The MDS indicated Resident 102 required supervision (helper provides verbal cues or touching assistance) for oral hygiene, toileting hygiene, upper/lower body dressing and putting on/taking off footwear and partial/moderate Assistance (helper does less than half the effort) for showering.</p> <p>During a review of Resident 102's Medication Administration Records (MAR - a daily documentation record used by a licensed nurse to document medications and treatments given to a resident) dated 3/1/2025 to 3/31/2025, the MAR indicated Resident 102 was ordered Glucerna (a nutritional supplement for people with diabetes) tube feeding on 3/14/2025.</p> <p>During a review of Resident 102's Care Plan Report dated 3/17/2025, the Report indicated Resident 102 required g-tube feeding due to dysphagia. The Report indicated a goal for Resident 102 to maintain adequate nutrition. The Report indicated interventions were to check MD's orders for current the feeding orders and to administer Glucerna via g-tube feeding.</p> <p>During an observation on 3/18/2025 at 12:17 PM in Resident 102's room, Resident 102's tube feeding was observed and infusing Jevity (high protein, fiber fortified therapeutic nutrition) via g-tube.</p> <p>(continued on next page)</p>		

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<p>F 0693</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a review of Resident 102's Interdisciplinary Team Review (IDT) dated 3/18/2025 at 12:28 PM, the IDT indicated Resident 102 was given the incorrect tube feeding when he was given Jevity instead of Glucerna.</p> <p>During a concurrent observation and interview on 3/18/2025 at 12:30 PM, with Licensed Vocational Nurse (LVN), Resident 102's tube feeding was observed. LVN 1 stated, he is getting Jevity 1.2 and not Glucerna 1.2 as ordered. This can be bad because he may be getting inappropriate nutrition if he's receiving the incorrect feeding and his condition may worsen. LVN 1 stated Resident 102 had the potential for weight loss and uncontrolled blood sugars.</p> <p>During a concurrent interview and record review on 3/20/2025 at 8:52 AM with the Director of Nursing (DON), the facility's P & P titled, Enteral Tube Feeding via Continuous Pump dated 11/2018 was reviewed. The P & P indicated to verify that there was a physician's order for this procedure. The P&P indicated to check the tube feeding label against the order before administration and to check they type of formula. The DON stated, Staff should check the order for tube feeding and ensure the feeding matches the ordered feeding. The DON stated when a feeding supplement was not available, the MD should be notified, and a new order must be obtained to administer a different feeding supplement. The DON stated licensed nurses (LN) should never hang a different feeding supplement than the one ordered by the MD. The DON stated Glucerna is not the same as Jevity because Glucerna is for patients with diabetes. The patient's blood sugar can get high if they receive a formula that is not ordered for them. If a diabetic patient's sugar gets high, they might feel dizzy and may get confused, they might get transferred to the hospital.</p>		

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<p>F 0732</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Some</p>	<p>Post nurse staffing information every day.</p> <p>48903</p> <p>Based on observation, interview and record review, the facility failed to ensure staffing information was complete and posted in a visible and prominent place daily in accordance with the facility's policy and procedure (P&P) titled, Posting Direct Care Daily Staffing Numbers.</p> <p>As a result, the total number of staff and the actual hours worked by the staff was not readily accessible to residents, staff, and visitors.</p> <p>Findings:</p> <p>During a concurrent observation and interview on 3/18/2025 at 10:38 AM with the Director of Staff Development (DSD), the Census and Direct Care Service Hours Per Patient Day (DHPPD; a form that provides staffing information for the day) posted near the facility's entrance was observed. The DSD stated, the DHPPD is not complete, it's missing the bottom documentation that shows the actual staffing, the top completed part is the projected staffing and was not done on 3/16/25 and 3/15/25. The DSD stated the DHPPD posting informs the staff, residents and visitors the actual staffing for that specific day, and that if the DHPPD was incomplete or not posted, the staff, residents and visitors would not be informed on the facility staffing.</p> <p>During an interview on 3/18/25 at 10:46 AM with the DSD, the DSD stated, the DHPPD should be posted on the second floor near the nursing station but was not.</p> <p>During a concurrent interview and record review on 3/20/2025 at 9:22 AM with the DSD, the facility's P & P titled, Posting Direct Care Daily Staffing Numbers dated 7/16 was reviewed. The P & P indicated the facility would post, on a daily basis for each shift, the number of nursing personnel responsible for providing direct care to residents. The P&P indicated the information recorded on the form shall include the actual time worked during a shift for each nursing staff and the total number of licensed and unlicensed staff. The P&P indicated staffing information must be posted within two (2) hours of the beginning of each shift with the total number of direct care staff. The DSD stated, the DHPPD was incomplete and that the DHPPD was not updated since the weekend.</p>		

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<p>F 0756</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48903</p> <p>Based on observation, interview, and record review the facility failed to conduct a monthly Medication Regimen Review (MRR, a monthly thorough evaluation by the consulting pharmacist of a resident's medication regimen, with the goal of promoting positive outcomes and minimizing adverse consequences and potential risks associated with medication) for one (1) of five (5) sampled residents (Resident 16) in accordance with the facility's Medication policy and procedure.</p> <p>This deficient practice had the potential to cause Resident 16 to receive unnecessary medication and to potentially have adverse reactions from medications.</p> <p>Findings:</p> <p>During a review of Resident 16's Admission Record indicated Resident 16 was admitted on [DATE] with diagnosis that included: chronic obstructive pulmonary disease (COPD-a chronic lung disease causing difficulty in breathing), anxiety (persistent and excessive worry that interferes with daily activities), bipolar disorder (sometimes called manic-depressive disorder; mood swings that range from the lows of depression to elevated periods of emotional highs) and dementia (a progressive state of decline in mental abilities).</p> <p>During a review of Resident 16's history and physical (H&P) dated 7/4/2024, the H&P indicated Resident 37 was able to make decisions for activities of daily living (ADLs- routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves)</p> <p>During a review of Resident 16's Minimum Data Set (MDS; a care assessment and screening tool) dated 2/18/2025, indicated the resident was not able to be assessed for cognition (capable of remembering, learning new things, concentrating, or making decisions that affect everyday life) and required supervision (helper provides verbal cues or touching assistance) for eating, oral hygiene, and upper body dressing. The MDS indicated Resident 16 required partial/moderate Assistance (helper does less than half the effort) for lower body dressing, putting on/taking off footwear and personal hygiene, and required substantial/maximal Assistance (helper does more than half the effort) for toileting and showering.</p> <p>During a review of Resident 16's Clinical Physician Orders (CPO) dated 2/2025 to 3/2025, the CPO indicated Resident 16 was prescribed Aricept (medication for dementia) 5 milligram (mg; unit of measurement for medication dose), Zyprexa (medication for bipolar) 15 mg, Namenda (medication for dementia) 10 mg, and klonopin (medication for anxiety) 1 mg.</p> <p>During a concurrent interview and record review on 3/19/2025 at 11:48 AM with the Director of Nursing (DON), the facility's MRR for 1/2025 to 3/2025 records were reviewed. The MRR records indicated there was no documented evidence of Resident 16's medications reviewed on the receiving an MRR. DON stated, this resident [Resident 16] does not have an MRR done. The purpose of the MRR is to monitor if a resident needs to continue taking certain medications. It is done for the patient's safety and to discontinue unnecessary medications.</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER Pasadena Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1570 North Fair Oaks Ave Pasadena, CA 91103	

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<p>F 0756</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 3/20/2025 at 2:05 PM with the facility's Consultant Pharmacist (CP) 1, CP1 stated, it's a state law that medications are reviewed monthly by doing a MRR to safeguard the resident and ensure that they are not receiving unnecessary medications. CP 1 stated MRR was conducted for the residents' safety.</p> <p>During a concurrent interview and record review on 3/20/2025 at 8:44 AM with the Director of Nursing (DON), the facility's P & P titled, Medication Therapy dated 4/2007. The P & P indicated the pharmacist shall review an individual's current medication regimen, and that each resident's medication regimen shall include only those medications necessary to treat existing conditions and address significant risks. The P&P indicated the consultant pharmacist shall review each resident's medication regimen monthly, as requested by the staff or when a clinically significant adverse consequence was confirmed or suspected. The DON stated, the pharmacist conducts the MRR monthly. The DON stated Resident 16 should have should have been reviewed during the pharmacist's MRR review since the medications prescribed to Resident 16 was he is receiving for dementia. The DON stated the MRR for Resident 16 was not conducted for the month of 2/2025. The DON stated when an MRR was not conducted, the pharmacist did not check if there was an adverse reaction or if the prescribed medication should be continued.</p>

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46087</p> <p>Based on interview and record review, the facility failed to maintain an accurate resident medical records for one of 17 sampled Residents (Resident 102) by failing to ensure electronic medication administration (eMAR, a daily documentation record used by a licensed nurse to document medications and treatments given to a resident) record was signed after administering resident's 8 AM medications on 3/19/2025.</p> <p>This deficient practice had the potential for staff to not know the medications that were administered to Resident 102 which could result in duplication or no administration of medications which could affect the resident's over all wellbeing.</p> <p>Findings:</p> <p>During a review of Resident 102's Admission Record, the Admission Record indicated Resident 102 was admitted to the facility on [DATE] with diagnoses of schizophrenia (a mental illness that is characterized by disturbances in thought), seizure (a sudden, uncontrolled electrical disturbance in the brain which can cause uncontrolled jerking, blank stares, and loss of consciousness dysphagia (difficulty swallowing), and gastrostomy (G-tube, a surgical opening fitted with a device to allow feedings to be administered directly to the stomach common for people with swallowing problems) status.</p> <p>During a review of Resident 102's Minimum Data Set (MDS; a resident assessment tool) dated 1/20/2025, indicated the resident had intact cognitive (capable of remembering, learning new things, concentrating, or making decisions that affect everyday life) skills for daily decision making and required:</p> <ol style="list-style-type: none"> 1. Set up or clean up assistance (helper sets up or cleans up) for eating 2. Supervision (helper provides verbal cues or touching assistance) for oral hygiene, toileting hygiene, upper/lower body dressing and putting on/taking off footwear. 3. Partial/Moderate Assistance (helper does less than half the effort) for showering. <p>During a review of Resident 102's medication administration record (MAR) dated 3/19/2025, timed at 8:30 AM, the following medications due at 9 AM did not have licensed nurse's initials/ signature:</p> <p>Losartan Potassium (medication to treat high blood pressure) tablet 25 milligrams (mg, unit of measurement), give 1 tablet via gastrostomy (G-tube, a surgical opening fitted with a device to allow feedings to be administered directly to the stomach common for people with swallowing problems) one time a day.</p> <p>Carvedilol (medication to treat high blood pressure) 12.5 mg tablet, give 2 tablets via G-Tube two times a day.</p> <p>(continued on next page)</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Divalproex sodium (medication used to treat certain types of seizures) delayed release sprinkle 125 MG, give four (4) capsule via G-Tube two times a day.</p> <p>Carbidopa-Levodopa (medication to treat Parkinson's disease [a progressive disease of the nervous system marked by tremor, muscular rigidity, and slow, imprecise movements]) 25-100 mg tablet, give 1 tablet via G-Tube three times a day.</p> <p>Insulin Lispro (a hormone that removes excess sugar from the blood, can be produced by the body or given artificially via medication) injection solution, three times a day.</p> <p>Ipratropium-Albuterol (medication to control symptoms of lung diseases) inhalation solution 0.5-2.5 (3) MG/3milliter (ml, unit of measurement) via nebulizer three times a day.</p> <p>Lactobacillus (supplement) capsule, give 1 capsule via G-Tube three times a day.</p> <p>During an observation in another resident rooms and interview on 3/19/2025 at 8:35 AM with Licensed Vocational Nurse (LVN) 1, LVN 1 stated she's about to give medication to another resident and LVN 1 already administered Resident 102's all morning medications due for 9 AM around 8 AM. LVN 1 stated she did not sign the eMAR yet because she is rushing to give all residents medication that is assigned to her medication cart. LVN 1 stated she did not and should have signed the eMAR right after administering medications to Resident 102.</p> <p>During a concurrent record review and interview on 3/19/2025 at 8:44 AM with MDS nurse (MDSN), Resident 102's eMAR dated 3/19/2025, timed 8:30 AM was reviewed. The eMAR did not have licensed nurse's initials/ signature on seven (7) medications (Losartan Potassium, Divalproex sodium, Carbidopa-Levodopa, Insulin Lispro, Ipratropium-Albuterol and Lactobacillus). MDSN stated Resident 102's due to be given at 9 AM today did not have the licensed nurse's signature which meant it was not administered yet. MDSN stated the proper way to administer medications is to sign the box for the medications that was administered for accurate documentation that it was given.</p> <p>During an interview on 3/20/2025 at 8:35 AM with LVN 2, LVN 2 stated documentation after administration of medication is part of the five rights (recommendations to reduce medication errors and harm) of medication administration for resident's safety and to prevent/avoid medication errors (any preventable event that may cause or lead to inappropriate medication use).</p> <p>During a review of Facility's Policy and Procedure (P&P) titled Charting and Documentation, revised in July 2017, indicated documentation of procedures and treatments will include care-specific details, including:</p> <p>The date and time the procedure/treatment was provided.</p> <p>Whether the resident refused the procedure/treatment.</p> <p>The signature and title of the individual documenting.</p> <p>(continued on next page)</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a review of Facility's P&P titled Administering Medication, revised in April 2019, indicated the following:</p> <p>Only persons licensed or permitted by this state to prepare, administer and document the administration of medications may do so.</p> <p>The individual administering the medication initials the resident's MAR on the appropriate line after giving each medication and before administering the next ones.</p> <p>As required or indicated for a medication, the individual administering the medication records in the resident's medical record:</p> <ol style="list-style-type: none"> a. the date and time the medication was administered. b. the dosage. c. the route of administration. d. the injection site (if applicable). e. any complaints or symptoms for which the drug was administered. f. any results achieved and when those results were observed; and g. the signature and title of the person administering the drug.

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45523</p> <p>Based on observation, interview and record review the facility failed to maintain an infection prevention control program by failing to label the oxygen tubing (the flexible hose or tube that connects an oxygen source (like a concentrator or cylinder) to a device that delivers oxygen to a resident, such as a nasal cannula [a flexible tube with two prongs, used to deliver supplemental oxygen through the nostrils, often for individuals experiencing breathing difficulties or needing oxygen therapy] or mask [a device worn over the nose and mouth through which oxygen is delivered]) and enteral feeding tube (a flexible, thin tube inserted into the gastrointestinal [GI] tract [the series of organs and structures that process food and absorb nutrients from it] to provide nutrition or medication directly into the stomach or small intestine) for two (2) of 17 sampled residents (Resident 102 and 29) in accordance with the facility's policy and procedure (P&P) titled Infection Prevention and Control Program by failing to:</p> <ol style="list-style-type: none"> 1. Label the enteral tube feeding with the date it was opened and initially used for Resident 29. 2. Label the enteral feeding tube and oxygen tube with the date it was opened/ initially use for Resident 102. <p>These deficient practices had the potential to cause Resident 102 to develop a respiratory (anything related to how we breath) related infectious disease and placed Resident 102 and 29 at risk for developing gastrointestinal (related to the stomach and digestive system) infection.</p> <p>Findings:</p> <ol style="list-style-type: none"> 1. During a review of the admission record, the admission record indicated Resident 29 was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included but not limited to unspecified protein calorie malnutrition (a disorder caused by a lack of proper nutrition or an inability to absorb nutrients from food), schizoaffective disorder (is a chronic mental illness that causes a person to experience dramatic changes in their thoughts, moods, and behaviors) other lack of coordination (a medical condition, often called ataxia, characterized by a loss of muscle coordination, leading to clumsy or jerky movements, unsteady gait, and difficulty with balance and fine motor skills) dysphagia, oropharyngeal phase (difficulty swallowing due to problems in the oropharynx [mouth and throat area], specifically during the oral and pharyngeal phases of swallowing, leading to impaired bolus [food/liquid mass] movement from the mouth to the esophagus), encounter for attention to gastrostomy (a medical visit or procedure focused on the care, maintenance, or management of a gastrostomy tube [G-tube-an artificial opening in the stomach used for feeding or medication delivery]). <p>During a review of Resident 29's Minimum Data Set (MDS, a resident assessment tool), dated 2/05/2025, indicated Resident 29 was severely impaired in cognitive skills (ability to understand and make decisions) for daily decision making. Resident 29 needed substantial assistance (helper does more than half the effort) from the staff for the activities of daily living such as eating, oral hygiene and upper body dressing and was totally dependent (helper does all of the effort) for toilet hygiene, shower, and lower body dressing.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a review of Resident 29's care plan, initiated on 1/30/2025 and revised on 3/03/2025, the care plan indicated Resident 29 is at risk for infection from stoma (an opening on the skin used to deliver food and liquids into the digestive system or intestine). The goal indicated the resident's insertion site will be free of s/sx (signs and symptoms) of infection.</p> <p>During an observation in Resident 29's room on 3/17/2025 at 9:14 AM, Resident 29 was awake, resting in bed, and was connected to enteral feeding tube hanging by the pole at bedside. The enteral feeding tube line did not have label to indicate the date when the enteral feeding tube was hung or initially used for Resident 29.</p> <p>During an interview with the IPN on 3/19/2025 at 12:48 PM, IPN stated, the enteral feeding tube is only good for use for 24 hours. IPN stated, the resident's enteral feeding tube must be labeled with the date when enteral feeding tube was hung or started on the resident. IPN then proceeded to confirm, per the facility's infection control policy, enteral feeding tubing must have a label with the date it was initially used on the resident. IPN stated, The tubing (enteral feeding tube) comes with a label (date of open/ started on the resident), not just the bottle, the tubing too. If the tubing (enteral feeding tube) is not changed, it is considered contaminated because it collects bacteria, or a virus and resident could get sick. We want to protect the residents as much as possible. If it does not have a date, we do not know when it (enteral feeding tube) was hung or when it needs to be changed.</p> <p>During an interview with the Director of Nursing (DON) on 3/19/2025 at 1:16 PM, the DON stated, The enteral feeding tube lines should have a date to help the nurses know when the enteral feed was hung and when it needed to be changed. The DON stated it was important to know when to change the entera feeding tube to prevent an infection that may come from the enteral feeding tube that is old/ has not been changed 24 hours after it was hung causing the resident harm.</p> <p>48903</p> <p>2. During a review of Resident 102's Admission Record, the admission record indicated Resident 102 was admitted on [DATE] with diagnosis that included type 2 Diabetes (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing), dysphagia (difficulty swallowing), schizophrenia (a mental illness that is characterized by disturbances in thought), and shortness of breath.</p> <p>During a review of Resident 102's history and physical (H&P) dated 8/20/2024, the H&P indicated Resident 102 was able to understand his medical condition.</p> <p>During a review of Resident 102's MDS dated [DATE], the MDS indicated the resident had intact cognition and required:</p> <ol style="list-style-type: none"> 1. Set up or clean up assistance (helper sets up or cleans up) for eating 2. Supervision (helper provides verbal cues or touching assistance) for oral hygiene, toileting hygiene, upper/lower body dressing and putting on/taking off footwear. 3. Partial/Moderate Assistance (helper does less than half the effort) for showering. <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a review of Resident 102's Clinical Physician Orders (CPO) dated 3/9/2025, the CPO indicated Resident 102's oxygen tubing and feeding tubing (enteral feeding tube) had to be labeled with date.</p> <p>During an observation on 3/17/2025 at 9:02 AM, Resident 102's oxygen tubing was observed not labeled with date it was initially used for Resident 102.</p> <p>During a concurrent observation and interview on 3/18/2025 at 9:09 AM with the Director of Staff Development (DSD), Resident 102's oxygen tubing was observed without a label of the date it was initially used for Resident 2. DSD stated, there was no label on the tubing (oxygen tubing), there should be a label and a date on the tubing for infection control.</p> <p>During a concurrent interview and observation on 3/18/2025 at 12:40 PM with Licensed Vocational Nurse (LVN) 1, Resident 102's tube feeding tubing was observed not labeled with the date it was first used for Resident 102. LVN 1 stated, the tubing (enteral feeding tube) is not labeled with a date and time. It must be changed every 24 hours. If it is not dated, we do not know if it has been changed and the tubing can grow bacteria which may get the resident sick.</p> <p>During an interview with the Infection Preventionist Nurse (IPN) on 3/19/2025 at 12:59 PM, IPN stated, The tubing of the tube feeding (enteral feeding tube) should be labeled with a date, and it should be changed every 24 hours. The feeding can go bad in the tubing and grow bacteria. Then if the resident receives the feeding (formula) they can get sick or get an infection. The oxygen tubing should be changed once a week, or if any part of it touches the floor because it grows bacteria over time. The oxygen tubing collects bacteria, and the resident could get sick with a respiratory infection if it is not changed. If it is not dated the tubing is considered dirty and it needs to be changed.</p> <p>During a concurrent interview and record review on 3/20/2025 at 8:59 AM with the Director of Nursing (DON), the facility's P & P titled, Infection Prevention and Control Program dated 12/2023. The P & P indicated:</p> <ol style="list-style-type: none"> 1. An infection prevention and control program (IPCP) is established and maintained to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. 2. Important facets of infection prevention include identifying possible infections or potential complications of existing infections. <p>The DON stated, The tubing of the enteral feeding and oxygen should be labeled with the date it was initially used for the resident because of infection control. If a tubing (enteral feeding tube and oxygen tubing) is not changed it grows bacteria that can cause a respiratory infection or stomach infection.</p>		

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<p>F 0912</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Some</p>	<p>Provide rooms that are at least 80 square feet per resident in multiple rooms and 100 square feet for single resident rooms.</p> <p>46087</p> <p>Based on observation, interview, and record review, the facility failed to provide the minimum 80 square feet (sq. ft., unit of measurement) per resident in multiple resident bedrooms for one (1) of 21 resident's rooms (Room A) in the facility.</p> <p>This failure had the potential to affect the residents' personal space, decrease freedom of mobility (the ability to move or be moved freely and easily) and could compromise the provision of care.</p> <p>Findings:</p> <p>During an observation and initial tour of the facility on 3/17/2025 at 10 AM, Room A did not meet the minimum requirement of 80 sq. ft. per resident.</p> <p>During a review of the facility's, Client Accommodation Analysis Form, dated 3/17/2025, indicated Room A, measured 158.2 sq. ft, which did not meet the 80 square footage requirement per resident.</p> <p>During a review of the room waiver (an agreement that you do not have to pay or obey) dated 3/17/2025, indicated:</p> <p>Room # of beds Sq. Ft. Sq. Ft. per bed</p> <p>1 (Room A) 2 158.2 79.1</p> <p>During a review of the facility's Room Waiver Request, dated 3/17/2025, indicated the facility's request for a waiver for Room A that measures less than 80 sq. ft. per resident. The Room Waiver Request also indicated that, There is enough space to provide for each resident's care, dignity and privacy, and The rooms are in accordance with the special needs of the residents and do not have any adverse effect on the residents' health and safety or impede the ability of any residents and the room to attain his/her highest practicable well-being.</p> <p>During a concurrent record review and interview with the Administrator (ADM) on 3/17/2025 at 2 PM, the Client Accommodations Analysis form (record of client accommodations approved for licensed care), dated 3/17/2025 was reviewed. The Client Accommodations Analysis form indicated Room A, measured 158.2 sq. ft. The ADM verified that all the residents' rooms aside from Room A met the required square footage per resident. ADM further stated, there have been no complaints about Room A being too small to accommodate the needs of the residents who reside in that room.</p> <p>(continued on next page)</p>		

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F 0912 Level of Harm - Potential for minimal harm Residents Affected - Some	During random observations and interviews from 3/17/2025 to 3/20/2025, Room A was observed with adequate (acceptable) ventilation (the movement of fresh air around a closed space) and lighting. The residents in the rooms have bathroom and toilet facilities. The residents were observed to have privacy curtains around their beds, which assured privacy. And there was adequate space for getting in and out of the wheelchairs and residents were afforded sufficient freedom of movement in the rooms. The residents verbalized they did not have complain regarding the space in their room. Observed that there was enough space for the staff to provide care and enough storage for residents' belongings and residents that are wheelchair bound were able to move in the room without difficulty.		

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<p>F 0921</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public.</p> <p>45523</p> <p>Based on observation, interview, and record review, the facility failed to dispose garbage (mostly decomposable food waste or yard waste) and keep two (2) of 2 garbage dumpsters/refuse (dry material such as glass, paper, cloth, or wood that does not readily decompose) containers covered and/or not overfilled with trash as indicated on the facility policy.</p> <p>These deficient practices had the potential to attract vermin (animals that are believed to be harmful, carry diseases such as rodents, parasitic worms, or insects), pests (any living thing that has a negative effect on humans), and wildlife (undomesticated animal species) that could potentially infiltrate the facility, affect the resident care areas and pose a disease threat to the residents and staff of the facility.</p> <p>Findings:</p> <p>During initial observation of the facilities parking lot on 3/17/2025 at 7:30 AM, observed facility parking lot area where garbage bins were located to have a total of 2 large metal garbage dumpsters that were overfilled with trash bags, both were not covered/ sealed and there was also visible trash on the floor surrounding the parking lot area.</p> <p>During a concurrent observation of the same facility parking lot area on 3/18/2025 at 5:30 AM, observed multiple empty cardboard boxes, a large black bin with trash bags inside and multiple trash bags placed on the floor of the parking lot.</p> <p>During an interview with Dietary Staff Supervisor (DSS) on 3/19/2025 at 9:00 AM, DSS stated the facility staff placed the trash on the floor and that could be a possible effect on vermin (animals that are believed to be harmful to crops, or that carry diseases) and other animals being attracted to the trash and potentially be harmful to the facility kitchen area affecting the food being served to the residents and potentially causing the residents' harm.</p> <p>During an interview with Housekeeper Staff (HKP1) on 3/19/2025 at 11:43 AM, HKP1 stated yesterday (3/18/2025), there was trash that needed to be thrown out in the afternoon, but the garbage dumpsters were not back from when they were picked up, they were across the street, so it was placed outside the facility's parking lot. HKP1 stated the trash that was on the floor were empty supply boxes from supplies that were delivered yesterday and/ or trash from kitchen. HKP1 stated since the trash dumpsters were not back before the last housekeeper left at 6:00 PM, the trash were placed on the floor outside in the parking lot. HKP1 stated the next day the janitor who comes in at 5:00 AM was supposed to make sure all the trash that was on the floor was placed inside the metal garbage dumpsters, but he was upstairs mopping and did not put the trash in the bins. KHP1 stated, I placed the trash in the dumpsters today when I came in at 6:00 AM, meaning the trash was out on the floor the whole night.</p> <p>(continued on next page)</p>

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NAME OF PROVIDER OR SUPPLIER Pasadena Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1570 North Fair Oaks Ave Pasadena, CA 91103	
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<p>F 0921</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a concurrent interview with HKP1 on 3/19/2025 at 11:50 AM, HKP1 stated if trash is left outside on the floor instead of inside the garbage dumpsters, it can attract vermin/ rodents like rats or cockroaches. HKP1 stated, some of the black trash bags that were left outside on the floor had dirty diapers and that could potentially attract dogs, cats or rodents and they can rip through the bags leaving dirty diapers all over the parking lot. HKP1 stated, it is not acceptable to leave trash on the floor, we should not leave it outside it is infection control and it is not hygienic (clean, especially in order to prevent disease).</p> <p>During an observation outside in the facilities parking lot on 3/19/25 12:41 PM in the presence of HKP1, observed Laundry Staff (LS1) walk outside with two large plastic trash bags and placed them next to a car in the parking lot by the area where the trash dumpsters should be. HKP1 stated, the trash will be placed on the floor and left outside because we do not have the trash dumpsters here accessible for us.</p> <p>During an interview with Infection Preventionist (IP) on 3/19/25 12:41 PM, IP stated everyone must practice infection control, to prevent the spread of viruses (particles that can cause disease) and bacteria keep the residents healthy. Ip stated leaving trash outside in the facilities parking lot instead of placing the trash inside the garbage dumpster it can potentially cause harm to the residents by inviting vermin, insects, rodents and cockroaches because they carry disease and can be potential for infestation (the presence of an unusually large number of insects or animals in a place, typically so as to cause damage or disease).</p> <p>During a concurrent interview with IP on 3/19/2025 at 12:49 PM, IP stated it is not acceptable to leave the trash outside on the floor because that is infection control issue, and the trash is not supposed to be on the floor because it is susceptible to rodents. IP stated, I am aware that this is happening. There is a gazebo (a roofed structure that offers an open view of the surrounding area, typically used for relaxation or entertainment) area near the trash area that is used for smoking area for the residents. It is not acceptable to leave the trash outside on the floor because the residents are in that area and potentially, they can come in contact with the trash and be exposed to bacteria due to dirty diapers or contamination in the area.</p> <p>During an interview with the facility Administrator (Admin) on 3/20/25 at 7:23 AM, Admin stated that depending on how long it takes for the garbage dumpsters to be put back in the parking lot after they are emptied out by the garbage pick- up company, the facility staff are instructed to place the trash on the floor in the parking lot.</p> <p>During an interview with Laundry Staff (LS1) on 3/20/2025 at 10:00 AM, LS1 stated, I am supposed to take out the trash before I leave at the end of my shift and leave my area clean for the next shift. When there is no garbage dumpster outside, I leave the trash on the floor in the parking lot. I know that the trash should be placed inside the garbage dumpsters and not placed outside or on the floor because it can leave bacteria, it is not hygienic, and it is possible for bacteria to spread. LS1 stated that the animals can come and rip the trash bags open, and all the trash can go all over the parking lot.</p> <p>During a review of the facility's Policy and Procedure (P&P) titled, Pest Control revised 5/2008, the P&P indicated, Our facility shall maintain an effective pest control program. The P&P indicated garbage and trash are not permitted to accumulate and are removed from the facility daily.</p> <p>(continued on next page)</p>		

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<p>F 0921</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a review of the facility's Policy and Procedure (P&P) titled, Waste Disposal, revised 1/2012, the P&P indicated, All infectious and regulated waste (waste potentially contaminated with blood, body fluids, or other materials that could spread infections, requiring specific handling and disposal methods) shall be handled and disposed of in a safe and appropriate manner.</p> <p>During a review of the facilities P&P titled Homelike Environment revised 2/2021, indicated Residents are provided with a safe, clean, comfortable and homelike environment. The P&P also indicated the facility staff and management maximizes, to the extent possible, the characteristics of the facility that reflect a personalized, homelike setting and these characteristics include clean, sanitary and orderly environment.</p>

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<p>F 0926</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Have policies on smoking.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46087</p> <p>Based on observation, interview, and record review, the facility failed to implement the facility's smoking policy for three (3) of 3 sampled smoking residents (Resident 4, 14, and 152). Residents 4, 14, and 152 were observed smoking without an apron on 3/17/2025 in accordance with the Smoking Safety Assessment anad/care plan.</p> <p>This deficient practice had the potential to result in harm and injury to the residents in the event of an accidental fire in the facility.</p> <p>Findings:</p> <p>1. During a review of Resident 4's Admission Record, the Admission Record indicated Resident 1 was admitted to the facility on [DATE] with diagnoses of schizophrenia a (a mental illness that is characterized by disturbances in thought), anxiety (a group of mental health conditions that cause excessive fear and worry), and limitation of activities due to disability.</p> <p>During a review of Resident 4's Admission/Re-admission Data Tool, dated 12/19/2024, timed at 11 AM. The tool indicated Resident 4's smoking safety evaluation, includes supervision and 1:1 assistance is needed. The tool indicated plan of care has been developed for safe smoking.</p> <p>During a review of Resident 4's Minimum Data Set (MDS - resident assessment tool), dated 1/30/2025, the MDS indicated Resident 4 had moderately impaired (decisions poor; cues/supervision required) of cognitive skills (ability to understand and make decisions) for daily decision making. The MDS indicated Resident 4 is independent (resident completes the activity by themselves with no assistance from a helper) with eating. The MDS indicated Resident 4 required setup or clean-up assistance (helper sets up or cleans up; resident completes activity) with oral hygiene and upper body dressing. The MDS indicated Resident 4 required supervision or touching assistance (helper provides verbal cues and/or touching/steadying and /or contact guard assistance as resident completes activity. Assistance may be provided throughout the activity or intermittently) with toileting hygiene, shower/ bathe self, lower body dressing, and putting on/taking off footwear, and picking up object.</p> <p>During a review of Resident 4's Care Plan (CP), initiated on 3/8/2025, the CP indicated Resident 4 is a smoker, and intervention includes Apron for smoking safety will be provided</p> <p>During an observation on 3/17/2025 at 8:55 AM with Resident 4, in the smoking area, Resident 4 was observed sitting in the bench, and smoking without a smoking apron.</p> <p>During an interview on 3/18/2025 at 11:40 AM with Resident 4, Resident 4 stated he never used an apron when smoking, and he added that it was never offered to him.</p> <p>During an interview on 3/20/2025 at 9:30 AM with Activity Director (AD), AD stated Resident 4 never used smoking apron, and she never seen Resident 4 used smoking apron.</p> <p>(continued on next page)</p>		

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<p>F 0926</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 3/20/2025 at 10:19 AM with MDS Nurse (MDSN), MDSN verified Resident 4's care plan indicated to use apron while smoking. MDSN stated there is no other CP indicating Resident 4's refusal to wear apron while smoking.</p> <p>2. During a review of Resident 14's Admission Record, the Admission Record indicated Resident 14 was admitted to the facility on [DATE] with diagnoses of schizophrenia, anxiety (a group of mental health conditions that cause excessive fear and worry), schizoaffective disorder (a mental illness that can affect thoughts, mood, and behavior), and Intermittent Explosive Disorder (IED, a mental health condition characterized by recurrent episodes of impulsive, aggressive, or violent behavior).</p> <p>During a review of Resident 14's Smoking Safety assessment dated [DATE], timed at 6:21 PM, indicated Resident 14 requires smoking apron.</p> <p>During a review of Resident 14's MDS, dated [DATE], the MDS indicated Resident 14 had moderately impaired cognitive skills for daily decision making. The MDS indicated Resident 14 is independent with eating. The MDS indicated Resident 14 required setup or clean-up assistance with oral hygiene and upper body dressing. The MDS indicated Resident 14 required supervision or touching assistance with toileting hygiene, shower/ bathe self, lower body dressing, and putting on/taking off footwear, and picking up object.</p> <p>During an observation on 3/17/2025 at 8:56 AM with Resident 14, in the smoking area, Resident 14 was observed standing in the smoking area, holding a stuff toy, and smoking without a smoking apron.</p> <p>During an interview on 3/20/2025 at 9:31 AM with AD, AD stated Resident 14 never used smoking apron, she never seen Resident 14 used smoking apron.</p> <p>During an interview on 3/20/2025 at 10:20 AM with MDSN, MDSN verified Resident 14's smoking safety assessment dated [DATE] indicated for Resident 14 to use smoking apron. MDSN added, smoking apron is for resident's safety, for them not to burn themselves.</p> <p>3. During a review of Resident 152's Admission Record, the Admission Record indicated Resident 152 was admitted to the facility on [DATE] with diagnoses of schizoaffective disorder, anxiety, and hallucinations (seeing, hearing, smelling, tasting, or feeling that seem real but are not).</p> <p>During a review of Resident 152's History and Physical (H & P) dated 3/13/2025, the H & P indicated Resident 152 is not competent to understand his/her medical condition and patient's bill of rights, therefore the staff is instructed to present this information to a family member, guardian, or conservator.</p> <p>During a review of Resident 152's Admission/Re-admitted Tool, dated 3/12/2025, timed at 8:02 PM, the tool indicated Resident 152's smoking safety evaluation indicated includes adaptive equipment such as supervision and smoking apron is needed. The tool indicated plan of care has been developed for safe smoking.</p> <p>During an observation on 3/20/2025 at 8:47 AM with Resident 152, in the smoking area, Resident 152 was observed smoking without a smoking apron.</p> <p>(continued on next page)</p>		

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<p>F 0926</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 3/20/2025 at 9:32 AM with Activity Director (AD), AD stated Resident 152 never used smoking apron since he got admitted here in the facility this month.</p> <p>During an interview on 3/20/2025 at 10:21 AM with MDSN, MDSN verified Resident 152's smoking assessment from the Admission/Re-admission Data Date Tool, dated 3/12/2025, the tool indicated for Resident 14 to use smoking apron. MDSN also stated, Resident 152's CP for smoking was only initiated on 3/18/2025, and should have been initiated on 3/12/2025, upon Resident 152's admission in the facility.</p> <p>During a review of Facility's Policy and Procedure (P&P), titled Smoking Policy-Resident, revised July 2017, indicated facility shall establish and maintain safe resident smoking practices. The P&P indicated the resident will be evaluated on admission to determine if he or she is a smoker or non-smoker. The P&P indicated a resident's ability to smoke safely will be re-evaluated quarterly, upon a significant change (physical or cognitive) and as determined by the staff. The P&P also indicated any smoking-related privileges, restrictions, and concerns (for example, need for close monitoring) shall be noted on the care plan, and all personnel caring for the resident shall be alerted to these issues.</p>		