STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555894	A. Building B. Wing	05/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Foothill Heights Care Center	1515 North Fair Oaks Ave Pasadena, CA 91103

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40037 Based on interview and record review, the facility failed to obtain informed consents (a process in which a health care provider educates a resident about the risks, benefits, and alternatives of a given procedure or intervention) for the use of psychotropic medications (medications that affect the mind, emotions, and behavior) for two (2) of five (5) sampled residents (Resident 44 and Resident 101) as indicated on the facility policy and procedure. 1. Facility failed to obtain an informed consent from Resident 44's Responsible Party (RP) prior to use of Seroquel (Antispychotic medication). 2. Facility failed to obtain an informed consent from Resident 101 prior to use of lorazepam (Antianxiety medication) and quetiapine (Seroquel). This failure resulted in violating resident's right to be fully informed of the risks and benefits of proposed care and treatment and not be able to make a choice on the treatment alternatives. Findings: 1. During a review of Resident 44's Admission Record indicated Resident 44 was admitted on [DATE], with diagnoses that included dementia (loss cognitive function of thinking, remembering and reasoning that interferes with a person's daily lift and activities) and psychosis (a severe mental condition in which thought, and emotions affected that contact is lost with external reality). During a review of Resident 44's Minimum Data Set (MDS, a resident assessment and care screening tool), dated 3/22/2024, indicated, Resident 44 was severely impaired with cognitive ((mental action or process of acquiring knowledge and understanding) skills for daily decision making. Resident 44 had clear speech, sometimes understood others and sometimes made self-understood. During a review of Resident 44's Order Summary Report indicated, Resident 44 was prescribed Seroquel (psychotropic medication) 100 milligram (mg, units of measure) two times a day for schizoaffective disorder on 9/21/2023. During a review of Resident 44's medical record, indicated, there was no informed consent obtained for Resident 44's use of Seroquel. (continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555894	A. Building B. Wing	05/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Foothill Heights Care Center	1515 North Fair Oaks Ave Pasadena, CA 91103

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview and concurrent record review on 5/5/2024 at 4:08 pm, the Infection Preventionist (IP) stated, there was no informed consent for Seroquel use for Resident 44 in Resident 44's medical record. The IP stated, any psychotropic medication required an informed consent before administered to resident so the resident would know risks and benefits for use of psychotropic medication. The IP stated, it was resident's right to be informed risks and benefits of psychotropic medication because it would affect resident' mind, emotion, and behavior. 34273 2. During a review of Resident 101's Admission Record, the Admission Record indicated Resident 101 was admitted to the facility on [DATE] with diagnoses which included anxiety disorder (fear characterized by behavioral disturbances) and schizophrenia (a serious mental illness that interferes with a resident's ability to think clearly, manage emotions, make decisions, and relate to others). During a review of Resident 101's History and Physical (H&P, physician's clinical evaluation and examination of the resident), the H&P indicated Resident 101 was able to make decisions for activities of daily living (ADL, basic self-care tasks which includes bathing or showering, dressing, personal hygiene, getting in and out of bed or a chair, walking, using the toilet, and eating). During an interview on 5/4/2024 at 10:06 AM with the Licensed Vocational Nurse 2 (LVN 2), LVN 2 stated Resident 101 was dependent on staff for ADL care. During a review of Resident 101's Physician's Order, dated 4/26/2024, the Physician's Order indicated quetiapine 50 milligrams (mg, a unit of measure) three times a day for hitting, striking, spitting at staff without provocation during ADL care. During a review of Resident 101's Medication Administration Record (MAR), dated 4/1/2024 - 4/30/2024, the MAR indicated LVN 2 gave the first dose of quetiapine 50 mg to Resident 101 on 4/27/2024 at 9 AM. During a review of Resident 101's Physician's Order, dated 4/30/2024, the Physician's Order indicated lorazepam 0.5 mg every 8 hours as needed for anxiety. During a review of Resident 101's MAR, dated 5/1/2024 - 5/31/2024, the MAR indicated LVN 1 gave Resident 101 the first dose of lorazepam 0.5 mg on 5/1/2024 at 2:40 PM. During a concurrent record review of Resident 101's clinical record and interview on 5/5/2024 at 12:01 PM with the IP, the IP stated was unable to find an informed consent from Resident 101 or RP for quetiapine and for lorazepam. The IPN stated informed consent must be obtained from the resident or RP prior to giving the medication to the resident. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555894	A. Building B. Wing	05/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Foothill Heights Care Center	1515 North Fair Oaks Ave Pasadena, CA 91103

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility's undated Policy and Procedure titled, Informed Consent, indicated, It is the policy of the facility to involve residents in their care decisions by facilitating information and obtaining consent for the use psychotropic drugs, physical restraints (any manual method or physical mechanical device, material or equipment attached or adjacent to the resident's body that the individual cannot remove easily which restricts freedom of movement or normal access to one's body) and medical devices that may lead to the inability of patient to regain use of a normal bodily functions after prolonged use. When initiating a new order or an increase in psychotropic drugs, the Attending physician must obtain informed consent from resident or responsible party.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555894	A. Building B. Wing	05/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Foothill Heights Care Center	1515 North Fair Oaks Ave Pasadena, CA 91103

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34273 Based on observation, interview, and record review, the facility failed to ensure the call light (a device used by a resident to signal their need for assistance from staff) was within sight and within reach for four (4) of 14 sampled residents (Residents 16, 35, 41, and 100) while in bed. This failure had the potential for Residents 16, 35, 41, and 100 to not be able to call for assistance if the residents desired to. Findings: 1. During a review of Resident 16's Admission Record, the Admission Record indicated Resident 16 was readmitted to the facility on [DATE] with diagnoses which included dementia (loss of memory, language, problem-solving and other thinking abilities that are severe enough to interfere with daily life) and Parkinsonism (brain conditions that cause slowed movements, rigidity/stiffness, and tremors). During a review of Resident 16's Minimum Data Set (MDS, a standardized assessment and care planning tool), dated 3/25/2024, the MDS indicated Resident 16's cognitive skills (functions that the brain uses to think, pay attention, process information, and remember things) for daily decision making was severely impaired. The MDS indicated Resident 16 was dependent on others for activities of daily living (ADL, basic self-care tasks which includes bathing or showering, dressing, personal hygiene, getting in and out of bed or a chair, walking, using the toilet, and eating). During an observation on 5/3/2024 at 6:45 PM in Resident 16's room, Resident 16 was observed resting in bed. Resident 16 was turned in bed, facing the left side. Resident 16's call light was observed clipped to the right side of his pillow and was out of Resident 16's sight and reach. 2. During a review of Resident 35's Admission Record, the Admission Record indicated Resident 35 was admitted to the facility on [DATE] with diagnoses which included cerebral infarction (stroke, damage to tissues in the brain which occurs because of disrupted blood flow to the brain) and encephalopathy (disturbance of the brain's functioning that leads to problems like confusion and memory loss). During a review of Resident 35's MDS, dated [DATE], the MDS indicated Resident 35's cognitive skills was severely impaired. The MDS indicated Resident 35 was dependent on others for ADL but only needed partial/moderate assistance (helper does less than half the effort) for eating. During a concurrent observation in Resident 35's room and interview on 5/3/2024 at 6:16 PM, Resident 35 was observed resting in bed. Resident 35 stated needing something but could not reach the call light clipped to the right side of his pillow. Resident 35's call light was noted to have a short red cord which was only long enough to reach the side of Resident 35's pillow and was out of resident's sight and reach. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555894	A. Building B. Wing	05/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Foothill Heights Care Center	1515 North Fair Oaks Ave Pasadena, CA 91103

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent observation in Resident 35's room and interview on 5/3/2024 at 6:16 PM, Resident 35 was observed resting in bed. Resident 35 stated needing something but could not reach the call light clipped to the right side of his pillow. Resident 35's call light was noted to have a short red cord which was only long enough to reach the side of Resident 35's pillow and was out of resident's sight and reach. During a concurrent observation in Resident 35's room and interview on 5/3/2024 at 6:20 PM with Assistant Director of Staff Development (ADSD), the ADSD adjusted Resident 35's call light and stated the call light cord was too short. ADSD stated she would inform maintenance staff to replace the call light. 3. During a review of Resident 41's Admission Record, the Admission Record indicated Resident 41 was readmitted to the facility on [DATE] with diagnoses which included encephalopathy. During a review of Resident 41's MDS, dated [DATE], the MDS indicated Resident 41's cognitive skills was moderately impaired. The MDS indicated Resident 41 was dependent on others to perform personal hygiene, to shower/bathe, to dress and undress below the waist, and to put on and take off footwear. The MDS indicated Resident 41 needed substantial/maximal assistance (helper does more than half the effort) for oral and toileting hygiene. During a concurrent observation in Resident 41's room, and interview on 5/3/2024 at 6:47pm, Resident 41 was observed resting in bed. The call light was clipped to the left side of Resident 41's pillow and was too short to reach the resident. Resident 41 stated, They give me a gadget to call for assistance. Resident 41's call light was out of Resident 41's sight and reach. 4. During a review of Resident 100's Admission Record, the Admission Record indicated Resident 100 was admitted to the facility on [DATE] with diagnoses which included fracture (a partial or complete break in the bone) of the fourth lumbar vertebra (one of the small bones forming the backbone/spine) and dementia. During a review of Resident 100's MDS, dated [DATE], the MDS indicated Resident 100's cognitive skills was severely impaired. The MDS indicated Resident 100 needed substantial/maximal assistance with eating, toileting hygiene, upper and lower body dressing, and putting on and taking off footwear. During a concurrent observation in Resident 100's room and interview on 5/3/2024 at 6:32 PM, Resident 100 was observed resting in bed. Resident 100 stated, I feel bad. Resident 100's call light was clipped to the left side of her pillow. The call light was noted to have a short red cord which was only long enough to reach the left side of Resident 100's pillow. Resident 100 stated she did not know and could not see where the call light was. During a concurrent observation in Resident 100's room and interview on 5/3/2024 at 6:35 PM with Licensed Vocational Nurse 4 (LVN 4) and Certified Nursing Assistant 1 (CNA 1), LVN 4 and CNA 1 stated Resident 100's call light cord was too short. LVN 4 stated, Some call lights in the facility were long but the red ones, like that one (Resident 100's call light) are a little short. A review of the facility's policy and procedure (P&P) titled, Answering the Call Light, undated, the P&P indicated, When the resident is in bed or confined to a chair be sure the call light is within easy reach of the resident .

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555894	A. Building B. Wing	05/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Foothill Heights Care Center	1515 North Fair Oaks Ave Pasadena, CA 91103

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34273 Based on interview and record review, the facility failed to ensure the responsible party (RP, responsible for guiding, informing, assisting, and advocating for residents in the healthcare system) for one (1) of two (2) sampled residents (Resident 38), who did not have the capacity to understand, received information regarding resident's right to formulate an advance directive (a legal document that states resident's wishes about receiving medical care if that resident is no longer able to make medical decisions because of a serious illness or injury). This failure had the potential to violate Resident 38's and Resident 38's RP's right to formulate an advance directive. Findings: During a review of Resident 38's Admission Record, the Admission Record indicated Resident 38 was admitted to the facility on [DATE] with diagnosis which included dementia (loss of memory, language, problem-solving and other thinking abilities that are severe enough to interfere with daily life). During a review of Resident 38's Advance Directives Acknowledgement Form (ADAF), dated 1/22/2024, the ADAF indicated Resident 38 signed the ADAF. During a review of Resident 38's History and Physical (H&P, physician's clinical evaluation and examination of the resident), dated 1/23/2024, the H&P indicated Resident 38 was not competent to understand medical condition. During a review of Resident 38's Minimum Data Set (MDS, a standardized assessment and care planning tool), dated 3/10/2024, the MDS indicated Resident 38's cognitive (mental action or process of acquiring knowledge and understanding through thought, experience, and the senses) skills for daily decision making was severely impaired. The MDS indicated Resident 38 required partial/moderate assistance (helper does less than half the effort) with upper body dressing and with putting on/taking off footwear. The MDS indicated Resident 38 required substantial/maximal assistance (helper does more than the effort) with lower body dressing and was dependent (helper does all the effort) with toileting hygiene and showering. During a concurrent record review of Resident 38's ADAF and clinical record and interview on 5/5/2024 at 9:57 AM with the Social Services Designee (SSD), the SSD stated the SSD was unable to find documentation that the advance directive was discussed with Resident 38's RP. The SSD stated the advance directive was supposed to be discussed and explained to Resident 38's RP and not with Resident 38 because Resident 38 lacked the capacity to understand medical condition. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555894	A. Building B. Wing	05/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Foothill Heights Care Center	1515 North Fair Oaks Ave Pasadena, CA 91103

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility's policy and procedure (P&P) titled, Advance Directives, dated 12/2016, the P&P indicated, Upon admission, the resident will be provided with written information concerning the right to refuse or accept medical or surgical treatment and to formulate an advance directive if he or she chooses to do so .If the resident is incapacitated or unable to receive information about his or her right to formulate an advance directive, the information may be provided to the resident's legal representative .

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555894	A. Building B. Wing	05/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Foothill Heights Care Center	1515 North Fair Oaks Ave Pasadena, CA 91103

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34273 Based on interview and record review, the facility failed to notify the physician (MD) of a change of condition for one of 14 sampled residents (Resident 22) after a fall on 4/24/2024. This deficient practice had the potential to not provide the necessary care and services needed by Resident 22, which can affect resident's overall wellbeing. Findings: During a review of Resident 22's Admission Record, the Admission Record indicated Resident 22 was readmitted to the facility on [DATE] with diagnoses which included head injuries, end stage renal disease (ESRD, when the kidneys can no longer clean the blood), and dependence on renal dialysis (a procedure where a machine cleans the blood because the kidneys can no longer clean the blood). The Admission Record indicated Resident 22 had a history of falling. During a review of Resident 22's History and Physical (H&P, physician's clinical evaluation and examination of the resident), dated 1/24/2024, the H&P indicated Resident 22 was competent to understand Resident 22's medical condition. During a review of Resident 22's Minimum Data Set (MDS, a comprehensive standardized assessment and screening tool), dated 3/31/2024, the MDS indicated Resident 22's cognitive skills (functions that the brain uses to think, pay attention, process information, and remember things) for daily decision making was severely impaired. The MDS indicated Resident 22 needed partial/moderate assistance (helper does less than half the effort) for toileting hygiene, for upper and lower body dressing, to put on and take off footwear, to transfer to and from a bed to a wheelchair, and to walk 10 feet. The MDS indicated Resident 22 needed substantial/maximal assistance (helper does more than half the effort) to shower/bathe and for personal hygiene. The MDS indicated Resident 22 did not have a fall prior to readmission to the facility on [DATE]. During a review of Resident 22's Situation, Background, Appearance, Review (SBAR, a standardized communication tool between healthcare providers), dated 4/24/2024 and timed 4:59 PM, Licensed Vocational Nurse 3 (LVN 3) indicated on the SBAR that Resident 22 fell off the wheelchair and sustained a laceration (skin wound) to the right eyebrow on 4/24/2024. The SBAR indicated Resident 22 appeared to be mildly confused and with poor judgement. The SBAR indicated, LVN 3 sent a message to the MD on 4/24/2024 at 5:15 PM. During a concurrent observation and interview on 5/3/2024 at 8:45 PM, LVN 3 stated he left a message for the MD but did not talk to the MD on 4/24/2024 at 5:15 PM. LVN 3 stated after a few minutes of not hearing back from the MD, LVN 3 sent a text message to the MD. LVN 3 stated in an emergency, the nurse would call the resident's primary MD, and if there was no response from the primary MD, the nurse would call the Medical Director. LVN 3 stated Resident 22's primary MD was the Medical Director. LVN 3 stated he only called and sent a text message to the MD once because Resident 22 was stable. LVN 3 stated he should have kept calling the MD. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555894	A. Building B. Wing	05/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Foothill Heights Care Center	1515 North Fair Oaks Ave Pasadena, CA 91103

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/3/2024 at 9:51 PM with LVN 4, LVN 4 stated in an emergency, if the resident's primary MD did not respond, LVN 4 would call the Medical Director. LVN 4 stated she would call, and not send a text message to the MD. LVN 4 stated when a resident sustains a laceration on the head, the MD would usually order stat (immediately) X-ray (photographic or digital image of the internal composition of something, especially a part of the body). During a phone interview on 5/4/2024 at 8 AM with Dialysis (process of removing waste products and excess fluid from the body) Nurse (DN), DN stated when Resident 22 went to dialysis on 4/25/2024, Resident 22 had a discoloration on the forehead and around the eyes, and a one-inch laceration above the right eyebrow with two thin adhesive bandages on it. DN stated Resident 22 was unable to explain what happened and how he sustained the laceration and discoloration around the eyes. DN stated Resident 22 complained of pain whenever dialysis nurses pointed to the discoloration around his eyes and to the laceration on his right eyebrow. DN stated the charge nurse in the dialysis center informed the Physician Assistant (PA) of Resident 22's discoloration around the eyes, the laceration on the eyebrow, and complaint of pain. The PA instructed the dialysis nurses to send Resident 22 to the general acute care hospital 1 (GACH 1) right away. DN stated Resident 22 left the dialysis center for GACH 1 on 4/25/2024 between 9 AM to 9:15 AM. During an interview on 5/4/2024 at 8:51 AM with the Director of Nursing (DON), the DON stated calling and sending a text message to the MD once after Resident 22 fell with a head injury was not enough. The DON stated LVN 3 should have called 911 (number to call during an emergency, which is any situation that requires immediate assistance from the police, fire department or ambulance) and should have sent Resident 22 out for evaluation when the MD did not respond. The DON stated Resident 22 was a fall risk and occasionally tried to get up out of the wheelchair without assistance. During an interview on 5/4/2024 at 1:15 PM, the MD stated for any unwitnessed fall with a head injury, the MD would instruct the nurses to send the resident to GACH for imaging (the process of using specialized techniques to produce an image of internal body organs), for evaluation, and for any repair which was the standard practice for unwitnessed fall with head injury. The MD stated if the resident's primary physician did not respond, the nurses usually reach out to the Medical Director. The MD stated if the nurse could not get a hold of the Medical Director and the resident's injury was severe then the nurse should send the resident to the hospital or reach out to the DON or try to call the MD again. The MD stated the nurses should make multiple attempts to get a hold of the MD. The MD stated, If I called back and (Resident 22) was with laceration, I definitely would send (Resident 22) to the hospital. During an interview on 5/4/2024 at 6:50 PM, LVN 1 stated for a resident who had an unwitnessed fall with a head injury, LVN 1 would assess the resident, inform the resident's physician, and then call 911. LVN 1 stated in an emergency, she would call the resident's physician at least two (2) to three (3) times. LVN 1 stated, I did not call the physician when I saw the resident's (Resident 22) discoloration around both eyes because a long time had already passed since his fall and I thought he (Resident 22) would be fine. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555894	A. Building B. Wing	05/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Foothill Heights Care Center	1515 North Fair Oaks Ave Pasadena, CA 91103

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the facility's P&P titled, Assessing Falls and Their Causes, dated 3/2018, the P&P indicated, If a resident has just fallen, or is found on the floor without a witness to the event, evaluate for possible injuries to the head, neck, spine, and extremities .If there is evidence of injury, provide appropriate first aid and/or obtain medical treatment immediately .When a fall results in a significant injury or condition change, notify the practitioner immediately by phone .Within 24 hours of a fall, begin to try to identify possible or likely causes of the incident .

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555894	A. Building B. Wing	05/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Foothill Heights Care Center	1515 North Fair Oaks Ave Pasadena, CA 91103

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Encode each resident's assessment data and transmit these data to the State within 7 days of assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44027 Based on interview and record review, the facility failed to transmit a Minimum Data Set (MDS, a standardized assessment and care-screening tool) Discharge Tracking Form (DTF, submitted when a resident has been discharged from the facility) to CMS (Centers for Medicare and Medicaid Services) within 31 days after a resident's DTF was completed for two of four sampled resident (Resident 17 and 37). This failure had the potential to result in an inaccurate assessment of the facility's quality indicators (standardized, evidence-based measures of health care quality that can be used with readily available in the healthcare setting) and/or care area concerns for review. Findings: A record review of Resident 17's Admission Record (AR), the AR indicated Resident 17 was admitted to the facility on [DATE] with multiple diagnoses including type 2 diabetes mellitus (a chronic condition that affects the way the body processes blood sugar), dementia (a group of thinking and social symptoms that interferes with daily functioning), and hyperlipidemia (a condition in which there are high levels of fat particles [lipids] in the blood). The AR indicated Resident 15 was discharged from the facility on 12/29/2023 to another facility. A record review of Resident 37's AR, the AR indicated Resident 37 was admitted to the facility on [DATE] with multiple diagnoses including Huntington's disease (a condition in which nerve cells in the brain break down over time), dementia, and acute respiratory failure (when the lungs can't get enough oxygen into the blood). The AR indicated Resident 37 was discharged from the facility on 1/20/2024 to General Acute Care Hospital (GACH). During an interview on 5/4/2024 at 3:34 pm with the MDS Consultant (MDSC), the MDSC stated Resident 17 was discharged from the facility on 12/29/2023. The MDSC stated Resident 17 was discharged home. The MDSC stated since Resident 17 was discharged home then the facility should have completed a Discharge Return not Anticipated (a DTF) and submitted Resident 17's DTF to CMS within 14 days of Resident 17 being discharged home. The MDSC stated Resident 17's DTF had not been submitted to CMS since resident was discharged from the facility last 12/29/2023. During the same interview on 5/4/2024 at 3:34 pm with the MDSC, MDSC stated Resident 37 was discharged from the facility on 1/20/2024. The MDSC stated Resident 37 was discharged to GACH. The MDSC stated since Resident 37 was discharged to GACH then the facility should have completed a Discharge Return Anticipated (a DTF) and submitted Resident 37's DTF to CMS within 14 days of Resident 37 being discharged to GACH. MDSC stated Resident 37's DTF had not been submitted to CMS. MDSC stated CMS needed the resident's (in general) DTF to keep track of resident data. The MDSC stated CMS needed accurate data about the residents. MDSC stated CMS wanted to know the length of stay at facilities for all residents. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555894	A. Building B. Wing	05/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Foothill Heights Care Center	1515 North Fair Oaks Ave Pasadena, CA 91103

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A record review of the facility's Manual titled, CMS's Resident Assessment Instrument (RAI, helps nursing home staff in gathering definitive information on a resident's strengths and needs) Version2.0 Manual, dated December 2002, indicated, With MDS Version 2.0, two new forms have been developed to track each resident's whereabouts in the health care system. The Discharge and Reentry Tracking forms provide key information to identify and track the movement of residents in and out of the facility. The Manual indicated, A Discharge-return not anticipated (Discharge Tracking Form) is completed when it is determined that the resident is being discharged with no expectation of return after a comprehensive Admission assessment has been completed. A discharge with return not anticipated can be a formal discharge to home, to another facility, or when the resident dies. The Manual indicated the Discharge Tracking Form was to be submitted no later than 31 days after the resident was discharged from the facility. A record review of the facility's Job Description titled, MDS Coordinator, undated, indicated, the MDS Coordinator was responsible to conduct and coordinate the development and completion of the resident assessment in accordance with current federal, state, and local standards that govern the facility . The Job description indicated the MDS Coordinator was responsible for the Coordination of RAI process including completion of MOS, CAA's and development of a comprehensive care plan of each resident as needed following RAI guidelines and facility policies.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555894	A. Building B. Wing	05/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Foothill Heights Care Center	1515 North Fair Oaks Ave Pasadena, CA 91103

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34273 Based on observation, interview and record review, the facility failed to develop a baseline care plan (initial goals based on admission orders which provides instructions for immediate care of the resident) for one (1) of 14 sampled residents (Resident 101) within 48 hours of Resident 101's admission to the facility. This failure had the potential for Resident 1 to not receive adequate and appropriate care. Findings: During a review of Resident 101's Admission Record, the Admission Record indicated Resident 101 was admitted to the facility on [DATE] with diagnoses which included anxiety disorder, schizophrenia (a serious mental illness that interferes with a person's ability to think clearly, manage emotions, make decisions, and relate to others), and malnutrition (occurs when the body does not get enough nutrients). During a review of Resident 101's History and Physical (H&P, physician's clinical evaluation and examination of the resident), the H&P indicated Resident 101 was able to make decisions for activities of daily living (ADL, basic self-care tasks which includes bathing or showering, dressing, personal hygiene, getting in and out of bed or a chair, walking, using the toilet, and eating). During an observation on 5/3/2024 at 7:15 PM in Resident 101's room, Resident 1 was noted to be on contact isolation precautions (used for infections, diseases, or germs that are spread by touching the resident or items in the room). Resident 101 was noted to be on gastrostomy tube (G-tube, a feeding tube inserted through the abdomen that brings nutrition directly to the stomach) feeding (liquid nutrition given through the G-tube). During an interview on 5/4/2024 at 10:06 AM, Licensed Vocational Nurse 2 (LVN 2) stated Resident 101 was dependent on staff for ADL care. During a concurrent record review of Resident 101's clinical record and interview on 5/4/2024 at 6:26 PM with Minimum Data Set (MDS, a comprehensive standardized assessment and screening tool) Consultant 2 (MDSC 2), the MDSC stated, was unable to find a baseline care plan. The MDSC 2 sated baseline care plans must be initiated upon the resident's admission to the facility and must be completed within 48 hours of admission. A review of the facility's Policy and Procedure (P&P) titled, Care Plans - Baseline, dated 12/2016, the P&P indicated, A baseline plan of care to meet the resident's immediate needs shall be developed for each resident within forty-eight (48) hours of admission .The baseline care plan will be used until the staff can conduct the comprehensive.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555894	A. Building B. Wing	05/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Foothill Heights Care Center	1515 North Fair Oaks Ave Pasadena, CA 91103

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34273 Based on interview and record review, the facility failed to develop and implement a care plan to address resident's behavior of getting up out of the wheelchair unassisted for one of 14 sampled residents (Resident 22) as indicated on the facility policy and procedure. This deficient practice had the potential for Resident 22 to fall and result in injury. Findings: During a review of Resident 22's Admission Record, the Admission Record indicated Resident 22 was readmitted to the facility on [DATE] with diagnoses which included head injuries, end stage renal disease (ESRD, when the kidneys can no longer clean the blood), and dependence on renal dialysis (a procedure where a machine cleans the blood because the kidneys can no longer clean the blood). The Admission Record indicated Resident 22 had a history of falling. During a review of Resident 22's History and Physical (H&P, physician's clinical evaluation and examination of the resident), dated 1/24/2024, the H&P indicated Resident 22 was competent to understand Resident 22's medical condition. During a review of Resident 22's Minimum Data Set (MDS, a comprehensive standardized assessment and screening tool), dated 3/31/2024, the MDS indicated Resident 22's cognitive skills (functions that the brain uses to think, pay attention, process information, and remember things) for daily decision making was severely impaired. The MDS indicated Resident 22 needed partial/moderate assistance (helper does less than half the effort) for toileting hygiene, for upper and lower body dressing, to put on and take off footwear, to transfer to and from a bed to a wheelchair, and to walk 10 feet. The MDS indicated Resident 22 needed substantial/maximal assistance (helper does more than half the effort) to shower/bathe and for personal hygiene. The MDS indicated Resident 22 did not have a fall prior to readmission to the facility on [DATE]. During a review of Resident 22's Quarterly Fall Risk Assessment, dated 4/1/2024 and timed at 10:43 AM, the Fall Risk Assessment indicated Resident 22 had balance problems while standing and walking, and had decreased muscular coordination. The Fall Risk Assessment indicated Resident 22 was at high risk to fall. During an interview on 5/4/2024 at 8:51 AM with the Director of Nursing (DON), the DON stated Resident 22 was a fall risk and occasionally tried to get up out of the wheelchair without assistance. During an interview on 5/5/2024 at 2:21 PM, Certified Nurse Assistant 4 (CNA 4) stated CNA 4 would put Resident 22 in the activity's hallway by the window or somewhere where staff would see him because he would try to get up while in the wheelchair. CNA 4 stated she would not leave Resident 22 in the room when resident is up in the wheelchair because Resident 22 would try to get on the bed by himself. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555894	A. Building B. Wing	05/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Foothill Heights Care Center	1515 North Fair Oaks Ave Pasadena, CA 91103

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent record review of Resident 22's clinical record and interview with Infection Preventionist Nurse (IPN) on 5/5/2024 at 3:10 PM, IPN stated Resident 22 did not and should have a care plan to address Resident 22's behavior of getting up out of the wheelchair without assistance to prevent falls. A review of the facility's Policy and Procedure titled, Care Plans, Comprehensive Person-Centered, dated 12/2016, indicated, A comprehensive, person-centered care plan that includes measurable objectives and timetable to meet the resident's physical, psychosocial, and functional needs is developed and implemented for each resident .

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555894	A. Building B. Wing	05/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Foothill Heights Care Center	1515 North Fair Oaks Ave Pasadena, CA 91103

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40037 Based on observation, interview and record review, the facility failed to ensure a nephrostomy (a surgical opening from the outside of the body to the renal pelvis [part of the kidney that collects urine] connected by a urinary tube/catheter [a plastic like tube placed in the body to drain and collect urine from the bladder {sac like that collects urine}]) bag was positioned below the bladder, the nephrostomy bag was placed on bed next to the resident, for one of two sampled residents (Resident 26), This deficient practice had the potential for urinary tract infection if the urine in the tubing or drainage bag back flow into kidney. Findings: During a review of Resident 26's Admission Record indicated Resident 26 was readmitted to the facility on [DATE], with diagnoses that included acute kidney failure (kidney suddenly become unable to filter waste products from blood) and infection (involves tissue invasion by microorganisms) and inflammatory (the body's response to a potentially damaging stimulus) reaction due to nephrostomy catheter. During a review of Resident 26's Minimum Data Set (MDS, a resident assessment and care screening tool) dated 2/17/2024, indicated Resident 26 had clear speech, usually understood others, and usually made self-understood. Resident 26 had impaired cognition (ability [NAME] understand and make decision). Resident 26 required substantial/maximal assistant (helper does more than half the effort-helper lifts or holds trunk or limbs and provides more than half the effort) for personal hygiene, roll left and right and sit to lying. Resident 26 had indwelling catheter (nephrostomy tube). During an observation in Resident 26's room and interview with Licensed Vocational Nurse 3 (LVN 3) on 5/3/2024 at 7:01 pm, in Resident 26's room, Resident 26 was lying in bed, Resident 26 had one nephrostomy bag on top of the bed near resident's left side of abdomen and one on top of the bed near the resident's right side of abdomen Resident 26's nephrostomy bags were placed next to the resident at same level of kidneys. LVN 3stated, Resident 26's nephrostomy bags should not placed at the resident's kidney level and ensure it is positioned lower the kidney level to avoid urine back flow to kidney causing infection and inflammation of the kidneys and decline of the resident's health condition. During an interview on 5/4/2024 at 10:18 am, the Director of Nursing (DON) stated, resident's nephrostomy bag should be placed below kidney level for proper draining of urine waste, making sure the urine would not back flow to kidney causing infection and for improve resident's health conditions. During a review of the facility's policy and procedure titled, Nephrostomy Tube, Care of, revised 10/2010, indicated, Drainage (nephrostomy bag) should be below the level of the kidneys.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555894	A. Building B. Wing	05/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Foothill Heights Care Center	1515 North Fair Oaks Ave Pasadena, CA 91103

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40037 Based on interview and record review, the facility failed to act upon the pharmacist's recommendations for A1C blood test (a blood test that provides information about levels of blood sugar over the past 3 months, used to diagnose type 2 diabetes [a disease that occurs when blood sugar is too high] and prediabetes) from medication regimen review (MRR, a thorough evaluation of the medication regimen of a resident, with the goal of promoting positive outcomes and minimizing adverse consequences associated with medication by pharmacist) for one (1) of 14 sampled residents (Resident 44). This failure had the potential to result in resident had uncontrolled blood sugar level that cause affect their health conditions. Findings: During a review of Resident 44's Admission Record indicated Resident 44 was admitted on [DATE], with diagnoses that included type 2 diabetes and psychosis (a severe mental condition in which thought, and emotions affected that contact is lost with external reality). During a review of Resident 44's Minimum Data Set (MDS, a resident assessment and care screening tool), dated 3/22/2024, indicated, Resident 44 had clear speech, sometimes understood others, and sometimes made self-understood. During a review of the facility's MRR including Resident 44's Note to Attending Physician/Prescriber dated 1/4/2024, indicated, Resident 44 had diabetes, but a recent A1C was not available in the resident record. Please consider monitoring an A1C on the next convenient laboratory day and then every 3 months if therapy has changed or goals are not being met. Or every 6 months if meeting treatment goals. During an interview and concurrent review of Resident 44's laboratory results from 1/4/2024 to 5/4/2024 on 5/4/2024 at 4:08 am with Infection Preventionist (IP), indicated, there was no A1C test performed. The IP stated, there was a blood test done on 4/5/2024 since 1/4/2024 and A1C test was not included. The IP stated, the facility did not follow the pharmacist's recommendation made on 1/4/2024 for performing A1C test. The IP stated, Resident 44 had diabetes, and it was important to have A1C blood test result to ensure Resident 44 received correct dose of blood sugar control medications for the resident. The IP stated, wrong dose of blood sugar control medication might cause resident's blood sugar too low or too high, and both will affect resident's health condition like kidney disease and heart disease. During a review of the facility's Policy and Procedure titled,Consultant Pharmacist Reports, effective 6/2021, indicated, The consultant pharmacist reviews the MRR of each resident at least monthly either on site or remotely. Recommendations are acted upon and documented by the facility by the facility staff and or the prescriber.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555894	A. Building B. Wing	05/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Foothill Heights Care Center	1515 North Fair Oaks Ave Pasadena, CA 91103

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40037 Based on observation, interview, and record review, the facility failed to ensure safe keep of medications when medications were left unattended during a medication administration observation for one of four sampled residents (Resident 34). This failure had the potential to result in loss of medications and/or other residents accessing the medications which could result in adverse effect (a harmful and undesired effect resulting from a medication or intervention) in the event that the medications were ingested. Findings: During a review of Resident 34's Admission Record, the Admission Record indicated Resident 34 was readmitted on [DATE], with diagnoses that included hypertensive heart disease with heart failure (heart problem caused by high blood pressure) and respiratory failure (a serious condition that makes it difficult to breathe on your own). During a medication administration observation at the hallway on 5/4/2024 at 8:17 am, Licensed Vocational Nurse 2 (LVN2) took out Resident 34's six medications and placed them individually in medication cups. LVN 2 left the six medication cups, with medications in them, on top of medication cart (a movable piece of equipment used in healthcare facilities to store, transport, and dispense medicines, medical supplies, and emergency equipment) unattended. There were residents and visitors observed passing by the hallway where the medication cart was with the medications in the medication cups. LVN2 went into Resident 34's room to take Resident 34's blood pressure. The medication cart was out of sight of LVN 2 when LVN 2 was inside Resident 34's room. During a concurrent interview on 5/4/2024 at 8:30 am, LVN 2 stated, Resident 34's medications should not have been left unattended in the hallway, which was an open area, while LVN2 was inside the resident's room. LVN 2 stated, Anyone who would have walked by, residents or visitors, could have taken these medications and cause harm to their health conditions if they accidentally took these medications. LVN 2 stated, It was for resident's safety that staff should keep medication in a safe place. During an interview on 5/4/2024 at 10:14 am, the Director of Nursing (DON) stated, licensed staffs should not leave medication unattended on the medication cart in hallway open area. The DON stated, Anyone could pass by and take the medications. The DON added, if other residents have taken the medications, it could cause adverse reaction to them and could cause harm to their health conditions. During a review of the facility's Policy and Procedure titled, Storage of Medications, revised 11/2020, indicated, Drugs and biologicals used in the facility are stored in locked compartments under proper temperature, light and humidity controls.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555894	A. Building B. Wing	05/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Foothill Heights Care Center	1515 North Fair Oaks Ave Pasadena, CA 91103

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44027 Based on observation, interview, and record review, the facility failed to remove and discard ground beef from the refrigerator after it was past the use by date according to the facility's policy and procedure (P&P) titled, Refrigerators and Freezers. This failure had the potential to result in residents to experience food-borne illnesses (an illness that comes from eating contaminated food. The onset of symptoms may occur within minutes to weeks and often presents itself as flu-like symptoms, as the ill person may experience symptoms such as nausea, vomiting, diarrhea, or fever). Findings: During a concurrent observation, interview, and record review on [DATE] at 5:57 pm with the Cook (CK) in the kitchen, a package of unfrozen ground beef was observed in the refrigerator. The package of ground beef was sitting in a stainless-steel pan that had a label on it indicating, ground beef for dinner [DATE]. The Meat Thawing Schedule, dated [DATE] was posted on the door of the refrigerator. The Meat Thawing Schedule indicated on [DATE], frozen ground beef was placed in the refrigerator to thaw. The Meat Thawing Schedule indicated the ground beef should have been used by [DATE]. CK stated the ground beef was expired and should have been discarded. CK stated thawed meet was only good for three days once it was thawed. The CK stated the ground beef was placed from the freezer to the refrigerator on [DATE] and it has been past three days. The CK stated the expired ground beef could get the residents sick. During an interview on [DATE] at 10:40 am with the Dietary Supervisor (DS), the DS stated kitchen staff put frozen meat in the refrigerator to thaw. The DS stated after ground meats are thawed, they are only good for one or two days. The DS stated all thawing meats needed to have a used by date and kitchen staff had to throw away any meat, if not used by the used by date. The DS stated if the meat was not removed after the used by date, it could cause foodborne illness to the residents. The DS stated the old ground meat could cause germs to spread in the refrigerator to other items the residents might eat. A record review of the facility's P&P titled, Refrigerators and Freezers, revised [DATE], indicated, the facility will observe food expiration guidelines. The P&P indicated, Supervisors will be responsible for ensuring food items in pantry, refrigerators, and freezers are not expired or past perish dates.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555894	A. Building B. Wing	05/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Foothill Heights Care Center	1515 North Fair Oaks Ave Pasadena, CA 91103

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0847 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Inform resident or representatives choice to enter into binding arbitration agreement and right to refuse. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44027 Based on interview and record review, the facility failed comply with requirements of Binding Arbitration Agreements (require that persons who signed them resolve any disputes by binding arbitration [alternative dispute resolution in which both parties agree to have their case heard by a neutral party instead of a judge and jury], rather than in court before a judge and/or jury) for three of three sampled residents (Residents 12, 19, and 200) when: 1. Facility failed to ensure Resident 12, who signed an Arbitration Agreement, dated 3/13/2024, understand what a Binding Arbitration Agreement was. 2. Facility failed to ensure Resident 19's Arbitration Agreement, dated 11/20/2020 was not signed in two locations/ options. It indicated, Resident 19 agreed to enter a Binding Arbitration Agreement and indicated the resident declined to enter a Binding Arbitration Agreement with the facility. 3. Facility failed to ensure Resident 200's (who is self-responsible) Arbitration Agreement, dated 4/30/2024, was not signed in two locations/ options. It indicated Resident 200 agreed to enter a Binding Arbitration Agreement and indicated the resident declined to enter a Binding Arbitration Agreement with the facility and the signature on the document was not Resident 200's signature. These failures had the potential to result in Resident 12, 14, and 200 to not be able to make an informed decision and/or their rights to be denied. Findings: 1. A record review of Resident 12's Admission Record (AR), indicated Resident 12 was admitted to the facility on [DATE] with multiple diagnoses including malignant neoplasm of cecum (colon cancer), back pain, and atrial fibrillation (an irregular, often rapid heart rate that commonly causes poor blood flow). A record review of Resident 12's Minimum Data Set (MDS, a standardized assessment and care screening tool), dated 3/20/2024, indicated Resident 12 had no impairment in cognitive skills (able to make daily decisions). The MDS indicated Resident 12 required partial/moderate (helper does less than half the effort) from staff for toileting hygiene and dressing. The MDS indicated Resident 12 required substantial/maximal assistance (helper does more than half the effort) from staff for bathing. A record review of Resident 12's Arbitration Agreement, dated 3/13/2024, indicated Resident 12 agreed to enter a binding arbitration agreement with the facility. During a concurrent interview and record review on 5/4/2024 at 4:00 PM with Resident 12, Resident 12 stated she signed the Arbitration Agreement, dated 3/13/2024. Resident 12 stated it was midnight when she was admitted to the facility. Resident 12 stated she did not know what a Binding Arbitration Agreement meant when facility asked her to sign it. Resident 12 stated it was very late when she signed the admission paperwork (including the Arbitration Agreement). Resident 12 stated no one explained the Arbitration Agreement to her before she signed it on 3/13/2024. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555894	A. Building B. Wing	05/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Foothill Heights Care Center	1515 North Fair Oaks Ave Pasadena, CA 91103

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0847 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. A record review of Resident 19's AR, indicated Resident 19 was admitted to the facility on [DATE] with multiple diagnoses including metabolic encephalopathy (brain disease that alters brain function or structure), adult failure to thrive (a decline in older adults that manifests as a downward spiral of health and ability), chronic obstructive pulmonary disease (COPD, a group of diseases that cause airflow blockage and breathing-related problems). A record review of Resident 19's MDS, a standardized assessment and care screening tool), dated 2/21/2024, indicated Resident 19 was severely impaired (never/rarely made decisions) in cognitive skills (ability to make daily decisions). The MDS indicated Resident 19 was dependent on staff for all care. A record review of Resident 19's Arbitration Agreement, dated 11/20/2020, was signed in two locations, indicated Resident 19 agreed to enter a Binding Arbitration Agreement and declined to enter a Binding Arbitration Agreement with the facility. 3. A record review of Resident 200's AR, indicated Resident 200 was admitted to the facility on [DATE] with multiple diagnoses including legal blindness, type 2 diabetes mellitus (a chronic condition that affects the way the body processes blood sugar), and cerebral infarction (also called ischemic stroke, occurs as a result of disrupted blood flow to the brain). A record review of Resident 200's History and Physical (H&P), dated 5/4/2024, indicated Resident 200 had fluctuating capacity to understand and make decisions . A record review of Resident 200's Arbitration Agreement, dated 4/30/2024, was signed in two locations, indicated Resident 200 agreed to enter a Binding Arbitration Agreement and declined to enter a Binding Arbitration Agreement with the facility. The signature on Resident 200's Arbitration Agreement was illegible. A record review of Resident 200's Consent for Medical Treatment, Bed Hold Notification Form, Advanced Healthcare Directive Acknowledgement Form and Physician Orders for Life Sustaining Treatment (POLST), dated 5/1/2024, the forms had a signature (by Resident 200) that indicated a first name, middle initial, and last name. The signatures were legible and similar to each other, and different from the signature on Resident 200's Arbitration Agreement. During an interview on 5/4/2024 at 6:08 pm with Accounts Payable/Admissions (AA), AA stated she assisted the Admissions department in explaining and getting signatures from residents for Arbitration Agreements. AA stated the facility did not have any evidence Resident 12 understood the Arbitration Agreement before they signed the Arbitration Agreement. During an interview on 5/5/2024 at 11:39 am with AA, AA stated Arbitration Agreement is an important part of the admission process. AA stated it was important residents (in general) understood what arbitration agreement was about because if residents signed the Arbitration Agreement, they would not be able to sue the facility. AA stated most residents did not sign an Arbitration Agreement. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555894	A. Building B. Wing	05/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Foothill Heights Care Center	1515 North Fair Oaks Ave Pasadena, CA 91103

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0847 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review on 5/5/2024 at 11:25 am with Resident 200, Resident 200's stated the signature on Resident 200's Arbitration Agreement was not Resident 200's signature. Resident 200 stated the Arbitration Agreement meant Resident 200 could not sue the facility if there was medical malpractice (refers to professional negligence by a health care provider that leads to substandard treatment, resulting in injury to a patient). Resident 200 stated he would never agree to that. Resident 200 stated to compare the signature to the other documents (Resident 1's Consent for Medical Treatment, Bed Hold Notification Form, Advanced Healthcare Directive Acknowledgement Form and POLST) Resident signed at the facility to see the difference from the signature on Resident 200's Arbitration Agreement. A record review of the facility's job description titled Admissions Coordinator, undated, indicated the duties and responsibilities of the Admissions Coordinator included: o Assist in the resident admission orientation program in accordance with our established policies and procedures. o Admit and prepare identification records for residents in accordance with established policies and procedures. o Provide residents with admission information packet (e.g., resident rights, notice of privacy practices, admissions contract, etc.) Review as necessary. o Obtain the resident/guardian's signature on all required permits, releases, authorizations, etc.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555894	A. Building B. Wing	05/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Foothill Heights Care Center	1515 North Fair Oaks Ave Pasadena, CA 91103

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40037 Based on observation, interview and record review, the facility staff failed to maintain an infection control measure designed to provide safe, sanitary equipment and prevent the development and transmission of disease and infection by failing to sanitize blood pressure cuff (device for measure blood pressure) between residents' use for two of six sampled residents (Residents 12 and 34). This deficient practice has the potential for communicable disease (also known as contagious disease, an infection transmissible by direct contact with an affected individual or the individual's body fluids or by indirect means like contaminated object) to spread out to others. Findings: During a review of Resident 34's Admission Record indicated, Resident 34 was readmitted on [DATE], with diagnoses that included hypertensive heart disease with heart failure (heart problem caused by high blood pressure) and respiratory failure (a serious condition that makes it difficult to breathe on your own). During a review of Resident 12's Admission Record indicated, Resident 12 was admitted on [DATE], with diagnoses that included disorder involving the immune mechanism (a part of the immune system is missing or not working properly) and after care flowing surgery for neoplasm (surgically remove an abnormal mass of tissue that forms when cells grow and divide more than they should). During a medication administration observation on 5/4/2024 at 8:17 am for Resident 34, with Licensed Vocational Nurse 2 (LVN2), LVN 2 took blood pressure for Resident 34 using a blood pressure cuff (the cuff is wrapped around your upper arm and inflated). LVN 2 did not sanitize with disinfectant wipes the blood pressure cuff and left it on medication cart (a movable piece of equipment used in healthcare facilities to store, transport, and dispense medicines, medical supplies, and emergency equipment). During a continuous medication administration observation on 5/4/2024 at 8:57 am for Resident 12, with LVN 2, LVN 2 used the same blood pressure cuff that was left on the medication cart, without sanitizing with a disinfectant wipe, and applied to Resident 12. During an interview on 5/4/2024 at 9:21 am, LVN 2 stated, LVN 2 did not sanitize the blood pressure cuff that used on Resident 12 after using the same blood pressure cuff for Resident 34. LVN 2 stated, LVN 2 should clean blood pressure cuff between residents' use to prevent possible bacteria transmission from one resident to another. LVN 2 stated, it was for infection control. During an interview o 5/4/2024 at 9:21 am, Infection Preventionist (IP) stated, staffs should sanitize medical device like blood pressure cuff between residents' use to prevent transmission of bacteria between residents. IP stated, infections could cause harm and declining health condition to residents. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555894	A. Building B. Wing	05/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Foothill Heights Care Center	1515 North Fair Oaks Ave Pasadena, CA 91103

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility's policy and procedure titled, Cleaning and Disinfection of Resident-Care Items and Equipment, revised 10/2018, indicated, Reusable items are cleaned and disinfected or sterilized between residents.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555894	A. Building B. Wing	05/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Foothill Heights Care Center	1515 North Fair Oaks Ave Pasadena, CA 91103

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34273 Based on interview and record review, the facility failed to implement its Policy and Procedure (P&P) for Influenza (a highly contagious viral illness that infect the nose, throat, and lungs) and Pneumococcal (pneumonia, infection of one or both lungs) Vaccination (treatment to a particular infectious disease) for one (1) of five (5) sampled residents (Resident 12) by failing to ensure: a. Resident 12's influenza vaccine and pneumococcal vaccine administration was recorded in Resident 12's Immunization Record. b. Resident 12 was monitored for side effects after Resident 12 received an influenza and a pneumococcal vaccine. These failures had the potential for Resident 12 to not receive care and treatment for side effects from the influenza and pneumococcal vaccines. Findings: During a review of Resident 12's Admission Record, the Admission Record indicated Resident 12 was admitted to the facility on [DATE] with diagnoses which included colon (main part of the large intestines, which absorb water and electrolytes from food that has remained undigested) cancer (a disease in which abnormal cells divide uncontrollably and destroy body tissue). During a review of Resident 12's History and Physical (H&P, physician's clinical evaluation and examination of the resident), the H&P indicated Resident 12 was competent to understand Resident 12's medical condition. During a review of Resident 12's Minimum Data Set (MDS, a standardized assessment and care planning tool), dated 3/20/2024, the MDS indicated Resident 12's cognitive (mental action or process of acquiring knowledge and understanding through thought, experience, and the senses) skills for daily decision making was intact. The MDS indicated Resident 12 walked independently and required supervision or touching assistance to partial/moderate assistance (helper does less than half the effort) with activities of daily living (ADL, basic self-care tasks which includes bathing or showering, dressing, personal hygiene, getting in and out of bed or a chair, walking, using the toilet, and eating). During an interview on 5/3/2024 at 6:30 PM, Resident 12 stated, I received an influenza shot on my right shoulder a week ago on Monday. Resident 12 stated her right shoulder was sore from the influenza shot. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555894	A. Building B. Wing	05/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Foothill Heights Care Center	1515 North Fair Oaks Ave Pasadena, CA 91103

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent record review of Resident 12's Clinical/Medical Record and interview on 5/4/2024 at 5:59 PM with the Infection Prevention Nurse (IPN), the IPN stated was unable to find documentation of Resident 12's influenza vaccination and pneumococcal vaccination. The IPN stated Resident 12's Influenza and Pneumococcal Vaccination Consent Forms, dated 4/16/2024, which indicated Resident 12 received both vaccinations, were and should not have been kept in the IPN's logbook. The IPN stated administration of influenza and pneumococcal vaccines must be documented on the Immunization Record and kept in Resident 12's clinical record. The IPN stated Resident 12 should have been monitored by licensed nurses for side effects every shift for 72 hours after administration of influenza and/or pneumococcal vaccine. The IPN reviewed Resident 12's nurses' notes and was unable to find any evidence Resident 12 was monitored for side effects after Resident 12 received influenza vaccine and pneumococcal vaccine. During an interview on 5/5/2024 at 3:49 PM with Registered Nurse 1 (RN 1), RN 1 stated after any immunization or vaccination, licensed nurses should monitor resident for side effects and any reaction to vaccine, monitor for fever, and injection site. During a review of the facility's undated Policy and Procedure (P&P) titled, Influenza Program: Vaccination, it indicated, The vaccine administration shall be documented in the Immunization Record in the resident's medical records and shall include the vaccine expiration date, lot number, date given, and signature .The resident's response to the vaccine .shall be observed and documented in the nurses' notes and/or the treatment record . During a review of the facility's P&P titled, Pneumococcal Vaccine, undated, the P&P indicated, Administration of the pneumococcal vaccines or revaccinations will be made in accordance with current Centers for Disease Control and Prevention (CDC) recommendations at the time of the vaccination . The P&P did not indicate where to document pneumococcal vaccine administration and did not indicate the resident's response to pneumococcal vaccine should be observed and documented in the resident's clinical record.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555894	A. Building B. Wing	05/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Foothill Heights Care Center	1515 North Fair Oaks Ave Pasadena, CA 91103

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0912 Level of Harm - Potential for minimal harm Residents Affected - Some	Provide rooms that are at least 80 square feet per resident in multiple rooms and 100 square feet for single resident rooms. 40037 Based on observation, interview and record review, the facility failed to ensure 13 out of 21 rooms (1, 9, 10, 11, 12, 14, 15, 16, 17, 18, 19, 20 and 21) met the square footage requirement of 80 square feet (sq. ft., unit of measurement) per resident in multiple resident rooms. This deficient practice has the potential to cause the residents in these rooms not to have enough room for activities of daily living and hinder staff from providing care to the residents. Findings: During an observation on 5/5/2024, from 9:09 am to 10:30 am, Rooms 1, 9, 10, 11, 12, 14, 15, 16, 17, 18, 19, 20 and 21 did not meet the minimum requirement of 80 sq. ft. per resident. The residents in these rooms were able to ambulate freely and/or maneuver in their wheelchairs freely. Nursing staff had enough space to provide care to these residents with dignity and privacy. There was space for beds, side tables, dressers, and other medical equipment. During an interview with the Administrator (ADM) on 5/5/2024, at 10:30 am, regarding these 13 resident rooms that did not meet the minimum requirement of 80 sq. ft. per resident in multiple resident rooms. The ADM stated that the ADM prepared a room waiver and would submit a room wavier for these resident rooms. A review of the facility's room waiver dated 5/4/2024, indicated that there was enough space for each resident's nursing and the health and safety of the residents occupying these rooms. The room waiver indicated these rooms were in accordance with the needs of the residents and would not have an adverse effect on the residents' health and safety or impede the ability of any resident to attain his or her highest practicable well-being. The room waiver showed the following: Room Sq. Ft. Beds 1 137.61 2 9 142.54 2 10 142.54 2 11 142.54 2 12 142.54 2 14 142.54 2 15 142.54 2 16 142.54 2 (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555894	A. Building B. Wing	05/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Foothill Heights Care Center	1515 North Fair Oaks Ave Pasadena, CA 91103

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0912 Level of Harm - Potential for minimal harm Residents Affected - Some	17 142.54 2 18 158.38 2 19 281.67 4 20 294.7 4 21 294.7 4 The minimum square footage for 2-bed rooms is 160 sq. ft. The minimum square footage for 3-bed rooms is 240 sq. ft. During interviews with residents both individually and collectively, they did not express any concerns regarding the size of their rooms. The Department would be recommending the room waiver for Rooms 1, 9, 10, 11, 12, 14, 15, 16, 17, 18, 19, 20 and 21 as requested by the facility.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555894	A. Building B. Wing	05/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Foothill Heights Care Center	1515 North Fair Oaks Ave Pasadena, CA 91103

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0940 Level of Harm - Potential for minimal harm Residents Affected - Some	Develop, implement, and/or maintain an effective training program for all new and existing staff members. 40037 Based on interview and record review, the facility failed to develop, implement, and maintain an effective training program for its staffs. This failure had the potential to result in staff not appropriately trained to improve resident safety, enhances the resident's quality of care and quality of life, and reduce the number of adverse events or other resident complications. Findings: During a concurrent interview with Infection Preventionist (IP) and record review on 5/5/2024 at 11:14 am of the facility's training program, and a review of the facility's In-Service Sign in Sheet (ISS), there were seven ISS sheets which was signed by staffs. These ISS sheets did not indicate the date of in-services, the length of training, topic, and brief summary of the lecture. The IP stated, all in services logs should include the in-service date, topic, summary of the lesson, duration and signatures from staffs who attended the in-services. The IP stated, without these (date of in-services, the length of training, topic, and brief summary of the lecture) information, the facility would not be able to know what training had been provided to the staffs, on which day and for how long. The IP stated it was very important to have an effective training program in place to make sure staffs received necessary training that may improve resident's quality of life and quality of care. During a review of the facility's policy and procedure titled, Staff Development Program, revised 5/2019, indicated, All personnel must participate in initial orientation and regularly scheduled in -service training classes. The primary objective of our facility's staff development program is to ensure that staff have the knowledge, skills, and critical thinking necessary to provide excellent resident care. All staff development classes attended by the employee are entered on the respective employee's employee training attendance record by the department director or other person designated by that director.