

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  555908	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  08/04/2025
NAME OF PROVIDER OR SUPPLIER  South Pasadena Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE  904 Mission St South Pasadena, CA 91030	

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0755  Level of Harm - Minimal harm or potential for actual harm  Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.  (continued on next page)

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observation, interview, and record review, the facility failed to: 1. Ensure Resident 1's phenytoin sodium (a medication used to treat seizures [a sudden, uncontrolled electrical disturbance in the brain which can cause uncontrolled jerking, blank stares, and loss of consciousness]) was available in stock to be administered on 7/25/2025 at its scheduled time of administration, in accordance with facility's policy and procedure (P&amp;P) titled, Administering Medications, dated 7/2024. 2. Ensure Resident 2's ergocalciferol (also known as vitamin D2 - a vitamin used to treat low levels of vitamin D) was available in stock to be administered on 8/4/2025 at its scheduled time of administration, in accordance with the facility's P&amp;P, titled Administering Medications, dated 7/2024. These deficient practices failed to ensure medications were available for two of three residents (Residents 1 and 2) that placed the residents at risk for vitamin D deficiency, seizures and hospitalization. Findings: 1. During a review of Resident 1's admission Record (a document containing demographic and diagnostic information), dated 8/4/2025, the admission record indicated, Resident 1 was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnosis that included, but not limited to, epilepsy, unspecified intractable, without status epilepticus (seizures that are difficult to control with medication, but do not involve prolonged seizures). During a review of Resident 1's History and Physical, dated 7/8/2025, the document indicated Resident 1 could make needs known but could not make medical decisions. During a review of Resident 1's Minimum Data Set ([MDS], a resident assessment tool) dated 7/11/2025, the MDS indicated Resident 1's cognition (mental action or process of acquiring knowledge and understanding through thought and senses) was intact. The MDS indicated Resident 1 needed supervision level assistance from the facility staff for activities of daily living (ADL - tasks of everyday life that include personal and oral hygiene, toileting, showering, and dressing) such as eating and moderate assistance for oral hygiene, toileting hygiene, showering, upper and lower body dressing and putting on or taking off footwear. During a review of Resident 1's Physician Order Summary Report (a document containing a summary of all active physician orders), dated 8/4/2025 and 7/28/2025, the order summary report indicated, Phenytoin sodium extended oral capsule 100 milligrams ([mg] a unit of measurement for mass), give 3 capsules by mouth two times a day related to epilepsy, 3 caps= 300mg, order date 8/3/2025, start date 8/3/2025 During an interview on 8/4/2025 at 1:40 p.m. with Resident 1, Resident 1 stated the facility ran out of his phenytoin 300 mg two times a day for seizures about a week ago. Resident 1 stated he did not remember the female Licensed Vocational Nurse's (LVN) name, but when Resident 1 requested the female LVN to administer phenytoin for afternoon dose, the female LVN stated that the facility did not have phenytoin in stock to administer to Resident 1 and the female LVN showed the empty medication card for phenytoin. Resident 1 stated he had been on the phenytoin for several years, for at least 10 years. Resident 1 stated, I was not feeling like myself and was acting a little slower and usually that was a usually a symptom leading up to a seizure, where he could move but could not talk. Resident 1 stated he was taken to the hospital the same day and the hospital ran a whole bunch of tests and Resident 1 stayed in the hospital for two days. Resident 1 stated he usually suffered from grand mal seizures (a type of epileptic seizure characterized by a loss of consciousness, muscle stiffening [tonic phase], and rhythmic jerking [clonic phase]) and he felt tired after suffering from an episode of grand mal seizures and Resident 1 stated the medications have helped to stabilize his condition. During a concurrent interview and record review on 8/4/2025 at 2:52 p.m. with LVN 1, Resident 1's Change of Condition (COC) dated 7/26/2025 was reviewed. The COC indicated altered mental status for Resident 1 on 7/26/2025. LVN 1 stated he was not the nurse taking care of Resident 1 on 7/25/2025 when the facility ran out of Resident 1's phenytoin. LVN 1 stated Resident 1 was taken to the hospital on 7/26/2025 but he was not sure if the resident was having seizures. LVN 1 stated if the facility ran out of stock of phenytoin and was not able to give it to Resident 1, it would increase the risk of seizures for Resident 1 and cause shortness of breath, altered mental status, fall risk because of uncontrolled body movements and hospitalization. During an interview on 8/4/2025 at 12:15 p.m. with pharmacist (RPH) 1, RPH 1 stated Pharmacy (PH 1- where the facility orders and received the resident's medications) delivered a 14-day supply of phenytoin 100 mg with instructions of three capsules two times a day to the facility on 7/8/2025 at 2:09 a.m. after receiving a request from the facility on 7/7/2025. RPH 1 stated the facility sent a fax to PH1 on 7/8/2025 at 6:01 p.m. that indicated, CancelRx meaning discontinuation of phenytoin 100 mg, 3 capsules two times a day. RPH 1 stated when the facility requested phenytoin order again on 7/19/2025 RPH 1</p>		

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that residents are free from significant medication errors.</p> <p>(continued on next page)</p>		

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on interview and record review, the facility failed to prevent significant medication error (a type of error which causes the resident discomfort or jeopardizes his or her health and safety) for Resident 1 by failing to ensure Resident 1's phenytoin sodium (a medication used to treat seizures [a sudden, uncontrolled electrical disturbance in the brain which can cause uncontrolled jerking, blank stares, and loss of consciousness]) was available in stock to be administered on 7/25/2025 at its scheduled time of administration, in accordance with facility's policy and procedure (P&amp;P) titled, Administering Medications, dated 7/2024. This deficient practice placed Resident 1 at risk for seizures, falls and other adverse consequences of not getting the medication. Findings:During a review of Resident 1's admission Record (a document containing demographic and diagnostic information), dated 8/4/2025, the admission record indicated, Resident 1 was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnosis that included, but not limited to, epilepsy, unspecified intractable, without status epilepticus (seizures that are difficult to control with medication, but do not involve prolonged seizures).During a review of Resident 1's History and Physical, dated 7/8/2025, the document indicated Resident 1 could make needs known but could not make medical decisions.During a review of Resident 1's Minimum Data Set ([MDS], a resident assessment tool) dated 7/11/2025, the MDS indicated Resident 1's cognition (mental action or process of acquiring knowledge and understanding through thought and senses) was intact. 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Resident 1 stated he usually suffered from grand mal seizures (a type of epileptic seizure characterized by a loss of consciousness, muscle stiffening [tonic phase], and rhythmic jerking [clonic phase]) and he felt tired after suffering from an episode of grand mal seizures and Resident 1 stated the medications have helped to stabilize his condition.During a concurrent interview and record review on 8/4/2025 at 2:52 p.m. with LVN 1, Resident 1's Change of Condition (COC) dated 7/26/2025 was reviewed. The COC indicated altered mental status for Resident 1 on 7/26/2025. LVN 1 stated he was not the nurse taking care of Resident 1 on 7/25/2025 when the facility ran out of Resident 1's phenytoin. LVN 1 stated Resident 1 was taken to the hospital on 7/26/2025 but he was not sure if the resident was having seizures. 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RPH 1 stated when the facility requested phenytoin order again on 7/19/2025, RPH 1 informed the facility via fax that facility needed to send a new order for Resident 1's phenytoin because facility had informed PH 1 to discontinue previous</p>		