

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 11/25/2025
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)
<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>(continued on next page)</p>

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

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

TITLE

(X6) DATE

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure one of two sampled residents (Resident 1) received all necessary services including an appointment with his oncologist (a medical professional specializing in the diagnosis, treatment, and prevention of cancer) as prescribed. This failure resulted in Resident 1 not receiving an evaluation and treatment plan for resident's non-Hodgkin lymphoma (NHL, a cancer that affects the lymphatic system [a network of organs, vessels and tissues that moves colorless fluid back to the bloodstream]). Findings: During a review of Resident 1's admission Record, the admission Record indicated Resident 1 was originally admitted to the facility on [DATE] with diagnoses that included non-Hodgkin lymphoma, end stage renal disease (ESRD - irreversible kidney failure), heart failure (a chronic condition in which the heart does not provide adequate blood flow to meet the body's needs), and adult failure to thrive (a decline caused by chronic diseases and functional impairments which can cause weight loss, decreased appetite, poor nutrition, and inactivity). During a review of Resident 1's General Acute Hospital (GACH) 1 Discharge to Skilled Nursing Facility (SNF) Summary and Transfer Orders, dated 5/6/2025, the Discharge Summary and Transfer Orders indicated Resident 1 had low grade b cell lymphoma (a type of NHL) and will be started on a treatment with rituximab (primarily used to treat various type of cancers) as outpatient. The Discharge Summary and Transfer Orders also indicated a follow up appointment scheduled with Oncologist 1 on 5/9/2025. During a review of Resident 1's Order Listing Report, the Order Listing Report indicated an appointment at GACH 1 on 5/9/2025 at 7:30 AM with Oncologist 1. During a review of Resident 1's Progress Notes, dated 5/9/2025, the Progress Notes indicated Resident 1 was not seen by Oncologist 1 at his appointment on 5/9/2025 at GACH 2 because of [medical] insurance problems. During a review of Resident 1's Minimum Data Set (MDS- a resident assessment tool), dated 7/11/2025, the MDS indicated Resident 1 had intact cognitive ((mental action or process of acquiring knowledge and understanding) skills for daily decision making. The MDS indicated Resident 1 required supervision or touching assistance (helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity) with eating and required partial/moderate assistance (helper does less than half the effort) personal hygiene. Resident 1 was dependent (helper does all the effort) with toileting hygiene and shower/bathing. During a concurrent interview and record review on 10/15/2025 at 2:54 PM with the Director of Nursing (DON), Resident 1's electronic medical chart was reviewed. The DON stated the electronic medical chart did not indicate a notification to Medical Doctor 1 (MD 1, Resident 1's primary care physician). MD 1 that Resident 1 was not seen at his oncology appointment on 5/9/2025 with Oncologist 1. The DON also stated the electronic medical chart did not indicate a rescheduled or completed appointment with the Oncologist 1. The DON stated Resident 1 was not seen by the Oncologist 1 due to insurance issues and per facility protocol, MD 1 should have been notified by staff so that another appointment could be scheduled. During an interview on 10/15/2025 at 3:54 PM with MD 1, MD 1 stated he should have been notified by staff when Resident 1 was not seen on 5/9/2025 by Oncologist 1 so he could find another oncology specialist that worked with Resident 1's insurance. During an interview on 10/16/2025 at 12:17 PM with the DON, the DON stated the facility did not follow the policy to ensure Resident 1 was seen by Oncologist 1 as prescribed. The DON also stated MD 1 was not and should have been notified. The DON stated and appointment was not rescheduled and should have been. The DON stated this was an important appointment for this resident so if it was cancelled, it should have been endorsed to Registered Nurse (RN) supervisor for her to follow up. The DON stated that without the oncology appointment, we could not ensure Resident 1 received all necessary care for cancer. During a review of the facility's policy and procedure (P&P) titled, Referral to Medical Specialist, dated 1/6/2025, the P&P indicated the purpose of the policy is to ensure timely, appropriate and coordinated referral of residents to medical specialist when indicated by clinical condition, physician recommendation, or resident/family request. The P&P also indicated: 1. The facility will facilitate resident access to necessary medical specialist consultations in collaboration with the attending physician, interdisciplinary team, and/or resident's responsible party. 2. Referrals shall be clinically justified, documented, and followed up in accordance with regulatory standards and facility procedures. 3. The Social Services Designee or Unit nurse contacts the specialist office to schedule the appointment.</p>		