

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 03/10/2026
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 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to document records accurately and completely for one (1) of three (3) sampled residents (Residents 1) in accordance with the facility's policy and procedure (P&P) by failing to ensure oxygen administered to Resident 1 on 2/9/26 was documented on the Medication Administration Record (MAR, a medical record used by healthcare providers to document the administration of a medication or treatment) and on the SBAR Situation, Background, Assessment, Recommendation (SBAR) Communication Form (communication tool that helps provide essential, concise information). This deficient practice can result in a lack of or a delay in communication between the staff and can interrupt provision of care/intervention to Resident 1. Findings: During a review of Resident 1's admission Record, the admission Record indicated Resident 1 was admitted to the facility on [DATE], with diagnoses of chronic lymphocytic leukemia of B-cell type not achieved remission (active cancer cells, with elevated lymphocyte counts or disease symptoms persisting despite treatment.) and malignant neoplasm of prostate (cancerous tumor that originates in the prostate [small, walnut sized gland located below the bladder] gland). During a review of the Minimum Data Set (MDS, a resident assessment tool), dated 12/10/2025, the MDS indicated Resident 1 was assessed to be cognitively (a mental process of acquiring knowledge and understanding) impaired with daily decision making. The MDS indicated Resident 1 required partial/moderate assistance (helper does less than half the effort. Helper lifts, holds, or supports trunk or limbs, but provides less than half the effort) on staff for oral hygiene, toilet hygiene, and personal hygiene. During a review of Resident 1's Order Summary, dated 1/23/2026, the Order Summary indicated to administer oxygen (O2) at two (2) to four (4) via nasal cannula (NC- a flexible tube inserted into the nostrils to deliver supplemental oxygen for patients with breathing difficulties) to five (5) to 10 liters per minute (LPM) via oxygen mask to reach O2 saturation (level of oxygen found in a person's blood) equal to or more than 92 percent (%) as needed for shortness of breath (SOB). Record O2 saturation before oxygen administration. During a review of Resident 1's MAR on February 2026, the MAR indicated to administer oxygen at 2 to 4 LPM via NC to 5 to 10 LPM via oxygen mask to reach O2 saturation equal to or more than 92% as needed for SOB and record O2 saturation before oxygen administration was blank on 2/9/2026. During a review of Resident 1's SBAR on 2/9/2026 at 4:06 PM, the SBAR did not indicate that oxygen was given upon finding Resident 1 to be unresponsive. During a concurrent record review of Resident 1's SBAR and Resident 1's MAR with LVN 1 on 3/6/2026 at 2:18 PM, LVN 1 stated, On 2/9/2026 at 3:30 PM, I administered oxygen at 10 LPM via oxygen mask to Resident 1 upon finding him unresponsive. I forgot to document in the MAR and in the SBAR communication form that oxygen was administered to him. LVN 1 stated he was supposed to document O2 saturation on the MAR and document that oxygen was administered on the SBAR. During a review of the facility's P&P titled, Charting and Documentation, dated May 2024, the P&P indicated all services provided to the resident, progress toward the care plan goals, or any changes in the resident's medical, physical, functional or psychosocial condition, shall be documented in the resident's medical record. The medical record should facilitate communication between the interdisciplinary team regarding the resident's condition and response to care.</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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