STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555908	A. Building B. Wing	07/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
South Pasadena Care Center	904 Mission St South Pasadena, CA 91030

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(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** 45099 Based on observation, interview, and record review, the facility failed to provide reasonable accommodations for resident needs and preferences for two (2) of 26 sampled residents (Residents 124 and 186) in accordance with the facility's policy when: 1. Resident 124's bathroom toilet seat was not at a comfortable and safe height for the resident. This deficient practice had the potential to result in a fall and injury to Resident 124. 2. Resident 186's call light was not within reach. This deficient practice had the potential for Residents 186 not to obtain necessary care and services to meet resident's needs. Findings: 1. A review of Resident 124's Admission Record indicated the resident was admitted to the facility on [DATE] and readmitted on [DATE] with a diagnosis that included Parkinson's disease (a brain disorder that causes unintended or uncontrollable movements, such as shaking, stiffness, and difficulty with balance and coordination). A review of Resident 1's History and Physical (H&P), dated 4/15/24, indicated Resident 124 has the capacity to understand and make decisions. A review of Resident 124's Care Plan initiated on 4/21/24, indicated Resident 124 had history of falls with a goal to minimize risk for fall/injury daily by the next three months. Staff intervention included was to anticipate of Resident 124's needs. A review of Resident 124's Minimum Data Set (MDS, standardized assessment and care screening tool), MDS dated [DATE], indicated Resident 124 had an intact cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decision making. The MDS indicated Resident 124 required supervision (helper provides verbal cues) with oral and personal hygiene, and upper body dressing. The MDS also indicated Resident 124 required partial assistance (helper does less than half the effort) with toileting hygiene and substantial/maximal assistance (helper does more than half the effort) with shower, lower body dressing and putting on/taking off footwear. (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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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent observation and interview on 7/16/24 at 9:20 AM, Resident 124 stated the toilet seat was too low for her to sit on and had hurt her bottoms tail end when she used it for the first time when she was readmitted back in April 2024. Resident 124 also stated the Maintenance staff was aware of the concern but was unable to change the toilet bowl . Resident 134 stated the roommate, and the residents next door were opposed to the change because they were shorter. Resident 124 further stated she does not like to struggle each time she uses the bathroom because the toilet seat being so low. Resident 124's toilet was observed to have vertical grab bar (secure rails mounted on the wall to help elderly individuals safely access and navigate rooms) beside the toilet seat which was observed low, approximately less than 2 feet from the floor. During an observation on 7/18/24 at 9:15 AM, Resident 124 tried to sit on the toilet bowl while holding the grab bar located on the right side of the toilet bowl and was seen struggling to sit down and stand up from a seated position. During an interview on 7/18/24 at 10:35 AM, the Licensed Vocational Nurse 8 (LVN 8) stated Resident 124's toilet seat should be higher to accommodate the resident's height to prevent another fall. During an interview on 7/18/24 at 12:05 PM, the MDS nurse stated the facility should have accommodated Resident 124's preference to have a higher toilet seat. During an interview on 7/18/24 at 2:38 PM, LVN 3 stated Resident 124 could be at risk for fall since she could get out of balance if the toilet seat is too low for her. During an interview 7/19/24 at 8:24 AM, the Director of Nursing (DON) stated, If the toilet seat was too low, it would be very hard for the resident to get up after using it. The DON also stated Resident 124 would be at risk for getting out of balance and could fall trying to use the bathroom. A review of the facility's Policy and Procedure titled, Accommodation of Needs, dated October 2023, indicated that the residents' individual needs and preferences shall be accommodated to the extent possible, except when the health and safety of the individual or other residents would be endangered. The policy also indicated that to accommodate individual needs and preferences, adaptations may be made to the physical environment, including the resident's bedroom and bathroom as well as common areas in the facility. 44636 2. A review of Resident 186's Admission Record indicated Resident 186 was initially admitted to the facility on [DATE] and readmitted on [DATE], with hemiplegia (a condition caused by brain damage or spinal cord injury that leads to paralysis [loss of motor function in one or more muscles] on one side of the body) and hemiparesis (weakness on one side of the body) following cerebral infarction (a stroke, damage to tissue in the brain due to loss of oxygen to the area) affecting right dominant side, right knee contracture (a condition of shortening and hardening of muscles, tendons, or other tissue, often leading to deformity and rigidity of joints), and urinary tract infection (UTI, an infection of the bladder and urinary system). (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident 186's MDS, dated [DATE], indicated Resident 186's cognitive skills for daily decision making were intact. The MDS indicated Resident 186 had an impairment on one side of the upper extremity (shoulder, elbow, wrist, hand) and one side of the lower extremity (hip, knee, ankle, foot). The MDS indicated Resident 186 was dependent (helper does all of the effort, resident does none of the effort to complete the activity, or the assistance of two or more helpers were required for the resident to complete the activity) for toileting hygiene, shower/bathe self, upper and lower body dressing, roll left and right, and sit to lying. The MDS indicated mobility such as sit to stand, chair/bed-to-chair transfer, and toilet transfer was not attempted due to medical condition or safety concerns for Resident 186. A review of Resident 186's Fall Risk Evaluation, dated 6/11/2024, indicated Resident 186 was at high risk for potential fall. A review of Resident 186's care plan, initiated 7/11/2024, indicated Resident 186 was at risk for falls related to poor body balance/control, history of falls, and medical condition such as cerebral vascular accident (CVA, stroke). Staff interventions included to keep the call light within easy reach, anticipate needs, and use of bilateral floor mat. During a concurrent observation and interview on 7/16/24 at 9:08 AM in Resident 186's room, Resident 186 was observed continuously calling out nurse. Resident 186 was lying in bed with body on the left side of the bed, both knees pointed to the left, and call light was not visible. Resident 186 stated he had been calling the nurse for half an hour since he needed to get his brief (protective underwear to prevent leakage) changed. Resident 186 stated he did not know where his call light was and was not able to reach his call light. During a concurrent observation and interview on 7/16/24 at 9:13 AM in Resident 186's room with Treatment Nurse 2 (TN 2), TN 2 stated Resident 186 was all the way to the left side of his bed. TN 2 stated Resident 186 was not able to reach his call light since the call light was on the right side of the bed placed underneath his pillow and Resident 186 was on the left side of the bed. During a concurrent observation and interview on 7/16/24 at 9:29 AM in Resident 186's room with TN 2, TN 2 stated Resident 186's call light was placed on his dresser. TN 2 stated Resident 186's call light was not supposed to be placed on the dresser since Resident 186 was not able to reach the call light. During an interview on 7/18/2024 at 9:35AM with Certified Nursing Assistant 7 (CNA 7), CNA 7 stated Resident 186's call light should be placed on his left side and kept within his reach since his right hand was weak. CNA 7 stated call lights were important to keep within Resident 186's reach in case of an emergency. During an interview on 7/19/2024 at 9:31 AM with Registered Nurse 1 (RN 1), RN 1 stated Resident 186's call light needed to be placed within Resident 186's reach since he was dependent and needed assistance with activities of daily livings (ADLs). During an interview on 7/19/2024 at 10:56 AM with the DON, the DON stated Resident 186 had right sided weakness and his call light should be placed within reach on the left side. The DON stated residents used their call light to receive assistance with ADLs, request of pain medication, or when they had any change in their condition. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the facility's Policy and Procedure titled, Call Lights, revised 8/2009, indicated assure that the call light is within the resident's reach when in their room.

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(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 - Some	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** 45456 Based on interview and record review, the facility failed to ensure two (2) of four (4) sampled Residents (Residents 16 and 286) and/or Residents' representatives were informed and provided written information regarding the right to formulate an advance directive (written statement of a resident's wishes regarding medical treatment, often including a living will, made to ensure those wishes are carried out should the resident be unable to communicate them to the doctor) in accordance with the facility policy and procedure. This deficient practice had the potential for Residents 16 and 286 or residents' representative to not know their rights and cause conflict in carrying out the Residents' wishes for medical treatment and health care decisions. Findings: 1. A review of Resident 16's Admission Record indicated Resident 16 was admitted to the facility on [DATE] and readmitted on [DATE]. A review of Resident 16's History and Physical (H&P, the initial clinical evaluation and examination of the resident), dated 6/5/24, indicated Resident 16 had diagnoses of multiple sclerosis (MS, a disorder of the central nervous system marked by weakness, numbness, a loss of muscle coordination, and problems with vision, speech, and bladder control), pulmonary edema (is when fluid collects in the air sacs of the lungs, making it difficult to breathe), and cardiomegaly (an enlarged heart). A review of Resident 16's Minimum Data Set (MDS, a standardized assessment and care planning tool), dated 6/7/24, indicated Resident 16 had intact cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decision making. The MDS also indicated Resident 16 was dependent (helper does all the effort. Resident does none of the effort to complete the activity) in toileting hygiene, shower/ bathe self, lower body dressing, and putting on/taking off footwear, sit to lying position, roll left and right. A review of Resident 16's Medical Record from 6/3/24 to 7/16/24, indicated there was no Advance Directive or advance healthcare directive acknowledgement form in the resident's chart or electronic medical record. During a concurrent record review of the Resident 16's chart and interview with the Admission Coordinator (ADC) on 7/18/24, at 2:08 PM, the ADC stated there was no copy of the advance healthcare directive acknowledgement form in the chart that was included with the Admission packet. ADC stated the advance healthcare directive acknowledgement form provides the resident/responsible party information regarding the right to formulate an advance directive. ADC stated the social worker was doing the follow up after the admission packet was provided to the resident or responsible party. 2. A review of Resident 286's Admission Record indicated Resident 16 was admitted to the facility on [DATE] and readmitted on [DATE]. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of Resident 286's H&P, dated 7/10/24, indicated Resident 16 had diagnoses of ventral (abdominal) hernia (any protrusion of intestine or other tissue through a weakness or gap in the abdominal wall) surgical wound infection, cerebral vascular accident (CVA, or stroke is an interruption in the flow of blood to cells in the brain), abdominal wall cellulitis (a serious deep infection of the skin caused by bacteria) A review of Resident 16's MDS dated [DATE], indicated Resident 16 had severely impaired cognitive skills for daily decision making. The MDS also indicated Resident 286 needed supervision or touching assistance (helper provides verbal cues/touching/steady/contact guard assistance as resident completes activity) with eating. Resident 286 was dependent in toileting hygiene, shower/ bathe self, lower body dressing, and putting on/taking off footwear. A review of Resident 286's Medical Record from 7/9/24 to 7/16/24, indicated there was no Advance Directive or advance healthcare directive acknowledgement form in Resident 286's chart or electronic medical record. During a concurrent record review of the Resident 286's chart and interview with the Social Services Director (SSD) on 7/18/24, at 2:49 PM, SSD stated there was no copy of the advance healthcare directive acknowledgement form in the chart. SSD stated, We have to keep advance directive acknowledgement form in the chart. SSD stated the advance directive acknowledgement was provided to the Resident or responsible party upon admission and it was included in the admission packet. SSD stated, We do the follow up quarterly and we offer it to the Resident if he has the capacity to make decision. During an interview with the Director of Nursing (DON) on 7/19/24, at 9:11 AM, the DON stated, Advance Directive should be kept in the chart. If they do not have an advance directive acknowledgement form should be in the chart. A review of the facility's Policy and Procedure titled, Advance Directives, revised on 8/23, 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. Written information will include a description of the facility's policies to implement advance directives and applicable state law.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44636 Based on observation, interview, and record review, the facility failed to provide a clean, comfortable, homelike environment for one of seven sampled residents (Resident 58). This deficient practice had the potential to result in the spread of diseases and infection. Findings: A review of Resident 58's Admission Record indicated Resident 58 was initially admitted to the facility 3/24/24 and readmitted on [DATE], with diagnoses of sepsis (a serious condition resulting from the presence of harmful microorganisms in the blood), gastrostomy (a surgical procedure for inserting a tube through the abdomen wall and into the stomach used for feeding or drainage) status, and quadriplegia (paralysis of all four limbs). A review of Resident 58's Care Plan, initiated 3/29/24, indicated Resident 58 had bladder and bowel function incontinence (inability to control). The care plan interventions were to clean after each episode of incontinency, assure good skin care, and maintain privacy at all times. A review of Resident 58's care plan, initiated 3/29/24, indicated Resident 58 was at risk for further decline in cognitive status. The care plan interventions were to maintain a reality- oriented relationship and pleasant environment, provide daily interaction during care, and provide safety and comfort measures. A review of Resident 58's Minimum Data Set (MDS, a standardized assessment and care planning tool), dated 7/3/24, indicated the resident's cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decision making were severely impaired. The MDS indicated Resident 58 was dependent (helper does all of the effort, resident does none of the effort to complete the activity) with toileting hygiene, upper and lower body dressing, personal hygiene, and sit to lying. The MDS indicated mobility such as sit to stand, chair/bed-to-chair transfer, and toilet transfer were not attempted due to medical condition or safety concerns for Resident 58. During a concurrent observation and interview on 7/16/24 at 8:38 AM in Resident 58's room with Certified Nursing Assistant 12 (CNA 12), CNA 12 stated there was fecal matter on the floor next to Resident 58's bed. CNA 12 stated the fecal matter appeared flattened, as if it had been run over by a wheel, such as a shower chair or wheelchair. During an interview on 7/18/24 at 11:04 AM with the Infection Prevention Nurse (IPN), IPN stated the expectation from staff was to provide proper activities of daily living care for residents. IPN stated once residents were cleaned after an incontinent episode, all fecal material should be placed in a plastic bag and put inside the trash. IPN stated there should be not fecal matter on the floor. IPN stated when residents' fecal matter was on the floor, it was an infection control concern with the potential to spread throughout the facility's premises. (continued on next page)

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	555908	A. Building B. Wing	07/19/2024

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 7/19/24 at 11:33 AM with the Director of Nursing (DON), the DON stated any fecal matter in the resident's room needed to be cleaned immediately since this was the resident's home environment. The DON stated the fecal matter on the floor could potentially lead to infections and posed a hazard due to unknown pathogens (any organism that causes disease such as bacteria, virus, fungi, and parasites) that could be present in the waste. A review of the facility's Policy and Procedure titled, Infection Control, dated 2020, indicated the facility has an established infection control program which has been designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of disease and infection. A review of the facility's Policy and Procedure titled, Homelike Environment, dated 10/2023, indicated the facility staff and management shall maximize, to the extent possible, the characteristics of the facility that reflect a personalized, homelike setting. These characteristics include a clean, sanitary, and orderly environment.

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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** 47362 Based on observation, interview, and record review, the facility failed to develop/implement residents' care plan for two (2) of 26 sampled residents (Residents 28 and 103) as indicated in the policy and procedure by failing to: 1. Implement the use of padded side rail for Resident 28 who has a diagnosis of epilepsy (brain disorder marked by sudden recurrent episodes of sensory disturbance, loss of consciousness, or convulsions, associated with abnormal electrical activity in the brain). This deficient practice had the potential to place the Resident 28 at risk for injuries. 2. Develop a care plan to address the treatment for Resident 103's suprapubic stoma site (surgically made hole above the pubic area). This deficient practice had the potential to increase Resident 103's risk for infection. Cross reference with F689 Findings: 1. A review of Resident 28's Admission Record indicated the resident was initially admitted to the facility on [DATE] with diagnoses of epilepsy, muscle weakness, and anxiety (a feeling of unease, such as worry or fear). A review of Resident 28's Minimum Data Set (MDS- a standardized assessment and care planning tool), dated 7/10/24, indicated Resident 28 had severe cognitive impairment status (mental action or process of acquiring knowledge and understanding). The MDS also indicated Resident 28 was dependent (helper does all of the effort) on oral hygiene, toileting hygiene, upper body dressing, lower body dressing and personal hygiene. The MDS also indicated active diagnoses of seizure disorder (seizures (uncontrolled bursts of electrical activities that change sensations, behaviors, awareness, and muscle movements) or epilepsy, Parkinson disease (a brain disorder that causes unintended or uncontrollable movements), and hemiplegia (paralysis that affects only one side of your body) or hemiparesis. A review of Resident 28's Order Summary Report indicated a physician's order dated 7/2/24 and with a start date of 7/3/24, may use both one fourth (1/4th) side rails up (a barrier attached to the side of a bed) and padded due to recurrent episodes of seizure disorder or fragile skin while in bed to enhance bed mobility and repositioning. A review of Resident 28's Care Plan, date initiated on 7/3/24, indicated resident uses padded 1/4th side rails for positioning, enabler, and for seizure precaution. The care plan also indicated the resident needs device (1/4th side [NAME]) due to poor bed mobility. The care plan goal indicated for the resident to be safe and minimize the risk of injuries. The care plan also indicated staff interventions were to ensure padded 1/4th side rails as ordered by medical doctor (MD). (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident 28's Interdisciplinary Team (IDT) Device Assessment, effective date 7/3/24, indicated after careful evaluation of the resident's condition, the IDT has weighed the risk and benefits for resident's best interest and recommended to proceed with the use of device padded side rails. During observation on 7/16/24 at 9:34 AM in the Resident 28's room, Resident 28's 1/4th side rails was up and was not padded. During concurrent observation and interview on 7/18/24 at 10:49 AM, license vocational nurse 3 (LVN 3) stated anytime residents are diagnosed with seizure, it was the facilty's normal practice to have padded side rails for resident's safety to prevent residents from hitting their head on the side rails. LVN 3 added, It was for the residents' protection). During concurrent observation and interview on 7/19/24 at 11:41 AM with the infection preventionist (IPN), IPN stated Resident 28's side rails was not padded. IPN also stated whatever was in the care plan should be implemented on the resident. IPN stated, the facility shoud have followed the physician's order. IPN stated Resident 28's side rails should be padded for the safety of Resident 28. 45099 Cross Reference with F690 2. A review of Resident 103's Admission Record indicated the resident was initially admitted to the facility on [DATE] and readmitted on [DATE] with a diagnosis of epilepsy. A review of Resident 103's Physician's Order, dated 5/30/24 at 9:13 AM, indicated Resident 103's suprapubic stoma site was to be cleaned with normal saline (NS, salt solution), pat dry and then covered with dry dressing everyday shift. A review of Resident 103's MDS dated [DATE], indicated Resident 103 had moderate impairment in cognitive skills for daily decision making. The MDS also indicated Resident 103 required partial assistance (helper does less than half the effort) with toileting hygiene and shower and required supervision (helper provides verbal cues) with oral and personal hygiene, lower body dressing, and putting on/taking off footwear. During a concurrent observation and interview on 7/16/24 at 8:56 AM, Resident 103's was seen scratching his lower abdominal area and stated it was itchy. Resident 103 was observed with suprapubic catheter and a dressing that was soiled and dirty. Resident 103 stated the dressing was last changed four (4) days ago and the suprapubic catheter site has not been cleaned. During a concurrent interview and record review on 7/18/24 at 10:31 AM, the wound care Treatment Administration Record (TAR) indicated that the suprapubic stoma site was dressed daily and was last signed by Treatment Nurse 1 (TN 1) on 7/16/24 and 7/17/24. TN 1 stated the last suprapubic stoma site dressing change on Resident 103 was on 7/12/24. TN 1 further stated the suprapubic stoma site dressing should be done daily to keep the Resident 103 from getting an infection on the site. During an interview on 7/18/24 at 2:52 PM, the Infection Prevention Nurse (IPN) stated Resident 103's suprapubic stoma site needed to be cleaned to prevent the risk for infection on the site. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 7/18/24 at 3:07 PM, LVN 3 confirmed there was no Care Plan related to the daily dressing change for the suprapubic stoma. LVN 3 stated the Care Plan should be updated so that the staff will be reminded that they should be doing the dressing as ordered. LVN 3 further stated the Care Plan helped serve as a communication tool for the nurses for the services that needed to be provided to the resident. A review of facility's Policy and Procedures (P&P) titled, Comprehensive Person Centered Care Plan, revised on 3/2024 indicated a comprehensive, person- centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident.

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	555908	A. Building B. Wing	07/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
South Pasadena Care Center	904 Mission St South Pasadena, CA 91030

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45099 Based on observation, interview, and record review, the facility failed to ensure one (1) of three (3) sampled resident (Resident 63) was provided a communication board (pre-printed picture board that has pictures, numbers, and user defined images that allows a resident to point or indicate on the board what he/she wants communicated) with the language the resident was able to understand in accordance with the facility policy. This failure had the potential to result in Residents 63 experiencing a delay in receiving appropriate care and treatment due to the staff not being able to properly communicate with the resident. Findings: A review of Resident 63's Admission Record indicated the resident was initially admitted to the facility on [DATE] and readmitted on [DATE] with a diagnosis of aphasia (a language disorder caused by damage to in specific area of the brain that controls language expression and comprehension), including hemiplegia and hemiparesis (a condition caused by brain injury that results in a varying degree of weakness, stiffness, and lack of control in one side of the body). A review of Resident 63's Care Plan initiated on 6/23/23 and revised on 4/2/24 indicated Resident 63 had a communication problem related to aphasia with a goal to be able to make Resident 63's basic needs known daily. The Care Plan interventions included Resident 63 required communication board and translators to communicate as needed. A review of Resident 63's Minimum Data Set (MDS, standardized assessment and care screening tool), dated 6/22/24, indicated Resident 63 had an intact cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decision making and was usually understood and understands. The MDS also indicated Resident 63 was dependent (helper does all the effort) with toileting, shower, lower body dressing, and putting on/taking off footwear and required substantial/maximal assistance (helper does more than half the effort) with upper body dressing. The MDS further indicated Resident 63 required partial assistance (helper does less than half the effort) with oral and personal hygiene. During an observation on 7/16/24 at 10:18 AM, Resident 63 was in bed awake. There was no communication board observed in the resident's room. During a concurrent observation and interview on 7/16/24 at 4:43 PM, Certified Nursing Assistant 8 (CNA 8) stated Resident 63 did not and should have a communication board in the room at all times. CNA 8 stated Resident 63 speaks a non-English language. During a concurrent record reviewof Resdient 63's care plan and interview with the MDS Nurse on 7/18/24 at 11:18 AM, the MDS nurse verified Resident 63's care plan indicated the resident required communication board and translation services as needed. The MDS nurse also stated and confirmed Resident 63 speaks a non-English language and the communication board should be in the resident's room so it could be readily available and accessible. (continued on next page)

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	555908	A. Building B. Wing	07/19/2024

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the facility's Policy and Procedure titled, Residents Rights: Communicating in a language the resident understands, dated May 2019, indicated that residents will be assessed for his/her ability to communicate in a language he/she understands. The policy also indicated that if the resident cannot communicate in the predominant language of the facility, the facility shall make reasonable attempts to provide communication, translation, and interpreter services.

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	555908	A. Building B. Wing	07/19/2024

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44636 Based on observation, interview, and record review, the facility failed to ensure grooming care assistance was provided for two (2) of three (3) sampled residents (Residents 43 and 75) as indicated in the facility policy. This deficient practice had the potential to lead to skin breakdown, poor hygiene, and diminished quality of life for Residents 43 and 75. Findings: 1. A review of Resident 43's Admission Record indicated Resident 43 was initially admitted to the facility on [DATE] and readmitted on [DATE], with diagnoses of metabolic encephalopathy (abnormalities of water, electrolytes, vitamins, and other chemicals that adversely affect the brain function), muscle weakness, and dementia (progressive brain disorder that slowly destroys memory and thinking skills). A review of Resident 43's Minimum Data Set (MDS, a standardized assessment and care planning tool), dated 7/3/24, it indicated the resident's cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decision making were severely impaired. A review of Resident 43's Care Plan, initiated 7/3/24, indicated Resident 43 required assistance in activities of daily living (ADLs). Staff interventions were to assist with grooming activities as scheduled or as needed, keep resident clean and dry at all possible times, and trim fingernails and file jagged edges if needed. During an observation on 7/17/24 at 4:25 PM in Resident 43's room, Resident 43 was lying in bed. Resident 43's fingernails were long and yellowish. During a concurrent observation in Resident 43's room and interview on 7/17/24 at 4:58 PM with Certified Nursing Assistant 9 (CNA 9), CNA 9 stated Resident 43's nails were big and a little bit yellow. CNA 9 stated Resident 43 was only able to move a few fingers and was not able to clip his own nails. CNA 9 stated Resident 43's fingernails needed to be trimmed. During an interview on 7/18/24 at 9:35 AM with CNA 7, CNA 7 stated CNAs (general) were responsible for clipping the residents' nails. CNA 7 stated Resident 43 would refuse ADL care. CNA 7 stated CNA 7 needed to notify the charge nurse when Resident 43 refused care and document it on the Stop and Watch (early warning tool when change identified while caring for or observing a resident). 2. A review of Resident 75's Admission Record indicated Resident 75 was initially admitted to the facility 4/24/24 and readmitted on [DATE], with diagnoses of contracture (a condition of shortening and hardening of muscles, tendons, or other tissue, often leading to deformity and rigidity of joints) of right and left hand, dementia, and Parkinson's Disease (progressive disease of the nervous system marked by tremor, muscular rigidity, and slow, imprecise movement) without dyskinesia (movement disorder that often appears as uncontrolled shakes, tics, or tremors). (continued on next page)

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	555908	A. Building B. Wing	07/19/2024

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of Resident 75's MDS, dated [DATE], indicated the resident's cognitive skills for daily decision making were severely impaired. The MDS indicated Resident 75 had impairment on both sides of his upper extremities (shoulders, elbows, wrists, and hands) and lower extremities (hips, knee, ankles, and feet). The MDS also indicated Resident 75 was dependent (helper does all of the effort, resident does none of the effort to complete the activity) for personal hygiene (ability to maintain personal hygiene, including combing hair, shaving, washing/drying face and hands). A review of Resident 75's Care Plan, initiated 6/29/24, indicated Resident 75 required assistance in ADLs related to Parkinson's Disease, dementia, and aging process. Staff interventions included were to assist with grooming activities as scheduled or as needed, shower two to three times a week, and trim fingernails and file jagged edges if needed. During an observation on 7/16/24 at 8:22 AM in Resident 75's room, Resident 75 was asleep in with and both hands were closed in a fist on his upper chest. During an interview on 7/17/24 at 10:09 AM with Resident 75's Responsible Party 2 (RP 2), RP 2 stated she was concerned since the facility did not trim his fingernails. RP 2 stated when she had visited Resident 75, she would usually have to trim Resident 75's fingernails since they were long. RP 2 stated she last visited Resident 75 on 7/13/24 and saw his long fingernails, however she was not able to trim his fingernails during the visit. During an observation on 7/17/24 at 11:03 AM in Resident 75's room, Resident 75's fingernails appeared long on both sides of the hand, extending beyond the tips of the fingers. During a concurrent observation in the resident's room and interview with CNA 9 on 7/17/24 at 4:44 PM with CNA 9, CNA 9 stated Resident 75 was dependent on staff for care. with CNA 9, CNA 9 stated both of his thumb fingernails were long, however he was unable to see the other nails since the resident's fists was closed. CNA 9 stated long fingernails could cause damage to Resident 75's palms and lead to an infection since his fists were closed. During a concurrent interview and records review on 7/18/24 at 9:57 AM with the Director of Staff Development (DSD) of the Stop and Watch forms, DSD stated there were no Stop and Watch forms completed for Residents 43 and 75 for July 2024. During a concurrent record review of Resident 43 and 75's SBAR (an acronym for Situation-Background-Assessment-Recommendation is a technique used to provide a framework for communication between members of the health care team) and care plans on 7/19/24 at 8:42 AM with Registered Nurse 1 (RN 1), RN 1 stated Resident 43 and 75 required assistance and were not able to clip their own nails. RN 1 stated it was the CNAs responsibility to clip the residents' nails. RN 1 stated CNAs needed to write down the resident's refusal of care on the CNA daily charting form when resident's refused care after three attempts and notify the charge nurse. During a concurrent record review of Resident 43 and 75's CNA daily charting with RN 1, RN 1 stated CNAs would document number seven to indicate refusal and what the resident refused. RN 1 stated there was no documentation for nail care refusal. During a concurrent record review of Resident 43 and 75's SBAR and care plans with RN 1, RN 1 stated there were no documentation of nail care refusal. (continued on next page)

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	555908	A. Building B. Wing	07/19/2024

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 7/19/2024 at 10:56 AM with the Director of Nursing (DON), the DON stated residents' nails were checked daily by CNAs and clipped as needed. The DON stated the residents' nails should not be kept long to prevent self-inflicted injuries. The DON stated long nails residents who were contracted could result with skin problems with self-inflicted injuries. A review of the facility's Policy and Procedure (P&P) titled, ADL Documentation, dated 2017, indicated the CNA will provide ADL care. A review of the facility's P&P titled, Supporting Activities of Daily Living (ADLs), reviewed 8/2024, indicated residents who are unable to carry out activities of daily living independently will receive the services necessary to maintain good nutrition, grooming, and personal and oral hygiene.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45456 Based on observation, interview, and record review, the facility failed to implement treatment for the prevention of pressure ulcer (painful wound caused as a result of pressure or friction) by failing to ensure that the low air loss mattress (LAL, mattress used for residents who are at risk for developing sores or already have pressure ulcer designed to circulate a constant flow of air for the management of pressure sores) was on the correct settings for two (2) of five (5) sampled residents (Residents 287 and 46), in accordance with the facility's policy and procedure. This deficient practice had the potential to place Resident 287 to have worsening stage 3 pressure ulcer (full-thickness skin loss in which subcutaneous fat may be visible in the ulcer and granulation tissue and epibole [rolled wound edges] are often present) and potential for Resident 46 to develop a pressure ulcer. Findings: 1. A review of Resident 287's Admission Record indicated the resident was admitted to the facility on [DATE]. Resident 287's diagnoses included cerebral palsy (CP, caused by damage to or abnormalities inside the developing brain that disrupt the brain's ability to control movement and maintain posture and balance), unstageable pressure ulcer (obscured full-thickness skin and tissue loss) of the right hip and Stage 3 Pressure Ulcer of the sacral region (it is a triangular-shaped bone at the base of the spine just superior to the coccyx[tailbone]). A review of Resident 287's Minimum Data Set (MDS, a standardized assessment and care-screening tool), dated 4/8/24, indicated Resident 287 has intact cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decision making. The MDS indicated Resident 287 was dependent (helper does all the effort, Resident does none of the effort to complete the activity) in toileting hygiene, shower/bathe self, lower body dressing, and putting on/ taking off footwear. MDS also indicated Resident 287 had three (3) pressure ulcers upon admission. A review of Resident 287's Physician's Order, dated 12/28/23, indicated to monitor placement, setting, and function ability of low air loss mattress every shift for wound/ skin management. During an observation in Resident 287's room, on 7/16/24 at 8:06 AM, Resident 287 was observed in bed with the LAL set on 120 pounds (lbs., unit of measurement). A review of the Monthly Weight Log indicated Resident 287's weight on 7/15/24 was 91 lbs. During a concurrent observation and interview with Resident 287 on 7/17/24, at 8:59 AM, Resident 287 was observed in bed with the LAL set on 120 lbs. Resident 287 stated, The mattress feels like I am laying on a stack of sand or it feels like I am laying on my waste (bowel movement). I always have to find ways to lay comfortably on it. I wish it could be slightly different. I wish it was like water that feels comfortable. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent observation in Resident 287's room and interview with the Licensed Vocational Nurse 7 (LVN 7) on 7/17/24 at 4:59 PM, LAL was observed set on 120 lbs. LVN 7 stated, The LAL was set up incorrectly. Resident 287 was 91 lbs. LAL should be set on 90 lb. setting. If the LAL was set incorrectly and the resident has pressure ulcer, the wound will take longer to heal. During an interview with the Director of Nursing (DON) on 7/17/24 at 5 PM, the DON stated, If the LAL was set up incorrectly, it depletes the purpose of the LAL mattress. The wound will not heal. If it is for prevention, the wound might develop. 2. A review of Resident 46's Admission Record indicated the resident was admitted to the facility on [DATE] and readmitted on [DATE]. Resident 46's diagnoses included cerebral infarction (refers to damage to tissues in the brain due to a loss of oxygen to the area), osteoarthritis (a type of arthritis [inflammation or swelling of one or more joints] that only affects the joints) of the bilateral hip and knees, and hypertension (high blood pressure) A review of Resident 46's MDS dated [DATE], indicated Resident 46 has severely impaired cognitive skills for daily decision making. The MDS indicated Resident 46 was dependent in oral hygiene, toileting hygiene, shower/bathe self, upper and lower body dressing, putting on/ taking off footwear, personal hygiene, roll left and right, sit to lying and lying to sitting on side of the bed, chair/bed-to-chair transfer, and tub/shower transfer. MDS also indicated Resident 46 was at risk for developing pressure ulcers. A review of Resident 46's Physician's Order, dated 4/17/24, indicated LAL Mattress for skin breakdown prevention. Check for setting, placement, and functioning of low air loss mattress every shift. A review of Resident 46's Braden Scale (is a standardized, evidence-based assessment tool commonly used in health care to assess and document a client's risk for developing pressure injuries), dated 7/12/24, indicated Resident 46 has total score of 12 or less which indicated high risk for skin breakdown. During an observation in Resident 46's room, on 7/16/24 at 9:05 AM, Resident 46 was observed in bed with the LAL set on 120 lbs. A review of the Monthly Weight Log indicated Resident 46's weight on 7/2/24 was 105 lbs. During a concurrent observation in Resident 46's room and interview with LVN 6 on 7/18/24, at 3:05 PM, Resident 46 was observed in bed with the LAL set on 120 lbs. LVN 6 stated, LAL was set on 120lbs. The LAL setting was incorrect. It should be on 105 lb. setting. We set the LAL based on the resident's weight. If the LAL setting was set on high, it depletes the purpose of the LAL Mattress. A review of the facility's Policy and Procedure (P&P) titled, Mattress, LAL/APP, dated 2020, indicated to decrease pressure from the Resident's weight in bed and promote the healing of or the prevention of pressure ulcers. Refer to manufacturer's recommendation for appropriate settings and guidelines as needed. A review of the undated Manufacturer's Manual titled, King Medical Supply (KMS) Alternating Pressure Pump & Mattress User Manual, indicated users can adjust air mattress to a desired firmness according to patient's weight or the suggestion from a health care professional.

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	555908	A. Building B. Wing	07/19/2024

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48395 Based on interview and record review the facility failed to ensure one (1) of three (3) sampled residents (Resident 106) received Restorative Nursing Assistant (RNA, nursing interventions that promote the resident's ability to adapt and adjust to living as independently and safely as possible) services as indicated in the physician's order. This failure had the potential to put Resident 106 at risk for decline in physical function and developing contractures (a permanent tightening of the muscles, tendons, skin, and nearby tissues that causes the joints to shorten and become very stiff). Findings: A review of Resident 106's Admission Record, indicated the resident was initially admitted to the facility on [DATE] with diagnoses of generalized (spread or extended throughout the body) weakness and neuromuscular dysfunction of the bladder (when the nerves and muscles do not work together well and as a result the bladder may not fill or empty correctly). A review of Resident 106's History and Physical Examination (H&P), dated 5/31/24, indicated the resident has the capacity to understand and make decisions. A review of Resident 106's Minimum Data Set (MDS, a standardized resident assessment care screening tool), dated 6/8/24, indicated the resident was moderately impaired with cognitive (ability to think, remember, and reason) skills for daily decision making. Resident 106 had impairment (being in an imperfect or weakened state or condition) on both sides for his upper extremities (shoulder, elbow, wrist, hand) and no impairment for his lower extremities (hip, knee, ankle, foot). Resident 106 was dependent (helper does all of the effort and resident does none of the effort to complete the activity) with toilet transfers, going from a lying to sitting on the side of the bed, rolling left and right in bed, upper and lower body dressing (how a resident puts on, fastens and takes off all items of clothing), and eating. A review of Resident 106's Order Summary Report dated 7/18/24, indicated a physician's order on 7/3/24 to start on 7/4/24 for Resident 106 to have: 1. RNA services for passive range of motion (PROM, a space in which a part of one's body can move when someone or something is creating the movement) for bilateral (both) lower extremities (legs/feet) every day (QD) five (5) days a week or as tolerated once a day 2. RNA services for bilateral upper extremities (arms/hands) active-assisted range of motion (AAROM, when the joint receives partial assistance from an outside force) QD 5 times a week as tolerated once a day. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident 106's RNA Program Care Plan dated 7/3/24, indicated Resident 106 was at risk for decrease in range of motion (ROM) to joint, at risk for contractures and at risk for loss of motion. The care plan interventions included were to provide gentle active/passive range of motion exercises as ordered, RNA program as ordered, RNA for bilateral upper extremity AAROM QD 5 times a week or as tolerated, and PROM to bilateral lower extremities QD 5 times a week or as tolerated. A review of Resident 106's Joint Mobility Assessment, dated 5/31/24, indicated Resident 106's bilateral lower extremities were within functional limits (full range of motion) and his bilateral upper extremities were impaired. During a concurrent interview and record review on 7/18/24 at 2:43 PM with RNA 1, the two RNA services binders dated July 2024 and Resident 106's Order Summary Report dated 7/18/24 were reviewed. No RNA services log for Resident 106 was found in either of the two RNA services binders and Resident 106's Order Summary Report indicated an order, dated 7/3/24, for the Resident to start RNA services on 7/4/24. RNA 1 stated that there is no documentation or log of RNA services being done for Resident 106. RNA 1 also verified that there was an order for Resident 106 to start RNA on 7/4/24. During an interview on 7/18/24 at 3:10 PM, the Director of Rehab (DOR), stated that once residents are discharged from physical therapy (therapy that is used to preserve, enhance, or restore movement and physical function), they will write an order for RNA services and once the nurses confirm the order, they will have the RNA sign off on receiving the resident's order and referral form. DOR also stated that the RNA services log form is where the RNAs sign their daily charting by initialing under the specific date which indicates that they have seen the resident on those days. DOR further stated that if the resident's RNA services log form was not filled out or initialed or was missing from the RNA services binder, then it means those services did not happen. During an interview on 7/18/24 at 3:18 PM, the Director of Nursing (DON), stated that once a task is done, it should be documented right away for accuracy and to avoid any staff member from forgetting what may have happened if they were to chart at a later time. The DON stated that it is not acceptable to be signing off on services performed for a resident two weeks later as they will not know if there were any significant changes with the resident. During an interview on 7/18/24 at 3:31 PM, Resident 106 stated that the last time anyone had come to help him move his upper and lower extremities was on 7/3/24 when he was discharged from physical therapy. Resident 106 stated that 7/3/24 was the last time he got out of bed and was placed into a chair and brought into the dining room. Resident 106 further stated that he felt like he might lose his functioning and would have to start all over again. During an interview on 7/18/24 at 3:34 PM, the DON stated RNA services help loosen the residents' joints and prevent contractures. The DON stated if residents do not receive the RNA services as ordered, it puts them at risk for activities of daily living (ADL, fundamental skills required to independently care for oneself such as eating, bathing and mobility) decline and developing contractures. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 7/19/24 at 9:22 AM, DOR and Registered Occupational Therapist (OTR, a healthcare provider who helps one improve their ability to perform daily tasks), DOR stated Resident 106 was discharged from therapy on 7/3/24 and that his RNA services order was to officially start on 7/4/24. DOR further stated that the purpose of RNA services is for the residents to maintain function, joint function and prevent decline and contractures. DOR stated if RNA services were not performed, it can put the resident at risk for further decline with their range of motion. A review of the facility's Policy and Procedure (P&P) titled, Restorative Nursing Services, dated July 2017, indicated, Residents will receive restorative nursing care as needed to help promote optimal safety and independence.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44636 Based on observation, interview, and record review, the facility failed to implement interventions to prevent accidents for three (3) of 3 sampled residents (Resident 58,103 and 28) who had history of seizures (burst of uncontrolled electrical activity between brain cells that causes temporary abnormalities in muscle tone or movements like stiffness, twitching or limpness) by failing to provide padded siderails (a barrier attached to the side of a bed) in accordance with the facility's seizure precaution policy. This deficient practice had the potential for Residents 58,103 and 28 to sustain injuries during a seizure disorder activity. Findings: 1. A review of Resident 58's Admission Record indicated Resident 58 was initially admitted to the facility 3/24/24 and readmitted on [DATE], with diagnoses of epilepsy (a brain disorder that causes unprovoked, recurrent seizures), quadriplegia (paralysis of all four limbs), and dementia (progressive brain disorder that slowly destroys memory and thinking skills). A review of Resident 58's Physician Order Summary Report, dated 3/25/24, indicated may pad 1/4 side rails on both sides of bed, monitor placement every shift. A review of Resident 58's care plan, initiated 3/29/24, indicated Resident 58 had a seizure disorder. The care plan indicated interventions were to maintain supervision and vigilance at all possible times, monitor side rails and positioning for possible injuries, and pad both side rails for seizure precaution. A review of Resident 58's Minimum Data Set (MDS, a standardized assessment and care planning tool), dated 7/3/24, indicated the resident's cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decision making were severely impaired. The MDS indicated Resident 58 was dependent (helper does all of the effort, resident does none of the effort to complete the activity) with toileting hygiene, upper and lower body dressing, personal hygiene, and sit to lying. The MDS indicated mobility such as sit to stand, chair/bed-to-chair transfer, and toilet transfer were not attempted due to medical condition or safety concerns for Resident 58. A review of Resident 58's Interdisciplinary Team (IDT, group of healthcare professionals from diverse fields who work in a coordinated manner toward a common goal for the resident) Conference Record, dated 7/5/24, indicated the IDT reviewed the resident's safety which included padding 1/4 side rails due to seizure. During an observation on 7/16/24 at 8:33 AM in Resident 58's room, Resident 58 was asleep on the bed with bilateral side rails up and padding noted on the right side rail and no padding on the left side rail. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555908	A. Building B. Wing	07/19/2024

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a follow up observation on 7/17/24 at 9:06 AM in Resident 58's room, Resident 58 was lying in bed awake with bilateral side rail up and padding on the right side rail and none on the left side rail. During a concurrent observation and interview on 7/18/24 at 2:20 PM in Resident 58's room with Certified Nursing Assistant 11 (CNA 11), CNA 11 stated only the right side rail had padding. CNA 11 stated padding should be placed on both side rails for Resident 58 since resident had seizures. During a concurrent interview and record review of Resident 58's physician order dated 3/25/24, on 7/19/24 at 9:05 AM with the Registered Nurse 1 (RN 1), RN 1 stated the physician ordered for both side rails to be padded and it is for safety precautions. RN 1 stated the bed side rails were metal and in the event of a seizure, Resident 58 could potentially fall or strike the side rails and get injured. During an interview on 7/19/24 at 11:33 AM with the Director of Nursing (DON), the DON stated residents with seizures, the side rails should be padded. The DON stated the padded side rails were a standard of practice to prevent injury when residents had seizures. A concurrent record review of Resident 58's physician order with the DON, the DON stated the order should be written as pad side rails on both sides and not may pad side rails on both sides. 45099 2. A review of Resident 103's Admission Record indicated the resident was initially admitted to the facility on [DATE] and readmitted on [DATE] with a diagnosis of epilepsy (seizure disorder). A review of Resident 103's MDS, dated [DATE], indicated Resident 103 had moderate impairment in cognitive skills for daily decision making. The MDS also indicated Resident 103 required partial assistance (helper does less than half the effort) with toileting hygiene and shower and required supervision (helper provides verbal cues) with oral and personal hygiene, lower body dressing, and putting on/taking off footwear. A review of Resident 103's Care Plan initiated on 6/4/24, indicated Resident 103 was high risk for injuries related to seizure disorder. Resident 103's Care Plan interventions included placement of pads to both siderails for seizure precaution. During an observation on 7/16/24 at 8:56 AM, the right-side rails of Resident 103' s bed was padded while the left side rails was missing the pad. During an interview on 7/17/24 at 10:06 AM, the Licensed Vocational Nurse 2 (LVN 2) stated Resident 103's side rails pad on the bed's left side rails was currently being cleaned at the laundry. LVN 2 also stated Resident 103 both side rails should have pads to protect the resident from hitting the rails in case he had seizure while the resident is in bed. A review of the facility's Policy and Procedure titled, Seizure Precautions, dated July 2019, indicated, residents will be protected prior to and during seizure activity. The policy also indicated that seizure precautions for residents who have a history of seizure activity included assessing for the need to pad side rails to prevent injury during seizure activity. (continued on next page)

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	555908	A. Building B. Wing	07/19/2024

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	47362 3. A review of Resident 28's Admission Record indicated the resident was initially admitted to the facility on [DATE] with diagnoses of epilepsy, muscle weakness, anxiety (a feeling of unease, such as worry or fear). A review of Resident 28's MDS, dated [DATE], indicated Resident 28 had severe cognitive impairment status. The MDS also indicated Resident 28 was dependent (helper does all of the effort) on oral hygiene, toileting hygiene, upper body dressing, lower body dressing and personal hygiene. The MDS also indicated active diagnosis seizure disorder or epilepsy, Parkinson disease (a brain disorder that causes unintended or uncontrollable movements), hemiplegia (paralysis that affects only one side of your body) or hemiparesis. A review of Resident 28's Order Summary Report indicated may use both one fourth (1/4th) side rails up and padded due to recurrent episodes of seizure disorder or fragile skin while in bed to enhance bed mobility and repositioning, ordered on 7/2/24, and start date on 7/3/24. A review of Resident 28's Care Plan, date initiated 7/3/24, indicated resident uses padded 1/4th side rails for positioning, enable, seizure precaution. The care plan also indicated the resident needs device (1/4th side [NAME]) due to poor bed mobility. The care plan indicated goal is that resident will be safe and minimize the risk of injuries. The care plan also indicated, interventions to ensure padded 1/4th side rails as ordered by MD (medical doctor). A review of Resident 28's IDT Device Assessment, effective date 7/3/24, indicated after careful evaluation of the resident's condition, the IDT has weighed the risk and benefits for resident's best interest and recommended proceed with the use of device padded side rails. During observation on 7/16/24 at 9:34 AM at Resident 28's room, Resident 28's 1/4th side rails was up and was not padded. During concurrent observation and interview on 7/18/24 at 10:49 AM the LVN 3, LVN 3 stated anytime residents diagnosed with seizure it was their normal practice to have padded side rails for resident's safety, to prevent residents from hitting their head on the side rails, and it was for residents' protection. During concurrent observation and record review on 7/19/24 at 11:41 AM with the infection preventionist (IPN), IPN stated Resident 28 side rails was not padded. IPN also stated whatever was in the care plan should be implemented on the resident and always follow physician's order. IPN stated Resident 28's side rails should be padded for the safety of Resident 28. A review of facility's Policy and Procedure titled, Care Plan, Comprehensive Person Centered, revised date 3/2024, indicated a comprehensive, person- centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 48395 Based on interview and record review the facility failed to provide necessary care and services for two (2) of three (3) sampled residents (Resident 106 and 103) by failing to: 1. Monitor Resident 106's Foley catheter (brand name for urinary indwelling catheter - a flexible tube inserted into the bladder that remains there to provide continuous urinary drainage) in accordance with the physician's order. This failure had the potential to place Resident 106 at risk for developing a urinary tract infection (UTI, an infection in any part of the urinary system). 2. Resident 103 suprapubic stoma site (surgically made hole above the pubic area) dressing was not changed daily as ordered. This deficient practice had the potential for Resident 103 to develop an infection at the suprapubic stoma site which could affect the health and well-being of the resident. Findings: 1. A review of Resident 106's Admission Record, indicated the resident was initially admitted to the facility on [DATE] with diagnoses of generalized (spread or extended throughout the body) weakness and neuromuscular dysfunction of the bladder (when the nerves and muscles do not work together well and as a result the bladder may not fill or empty correctly). A review of Resident 106's History and Physical Examination (H&P), dated 5/31/24, indicated the resident has the capacity to understand and make decisions. A review of Resident 106's Minimum Data Set (MDS, a standardized resident assessment care screening tool), dated 6/8/24, indicated the resident was moderately impaired with cognitive (ability to think, remember, and reason) ability for daily decision making. Resident 106 was dependent (helper does all of the effort and resident does none of the effort to complete the activity) with toilet transfers, going from a lying to sitting on the side of the bed, rolling left and right in bed, upper and lower body dressing (how a resident puts on, fastens and takes off all items of clothing), and eating. Resident 106 was assessed as having a urinary indwelling catheter. A review of Resident 106's Order Summary Report, dated7/18/24, indicated the following physician's orders dated 5/31/24: a. Monitor Foley Catheter for drainage, redness, bleeding, irritation, crusting or pain at the catheter urethral (the tube through which urine leaves the body) junction during catheter care every shift for foley catheter care. b. Monitor placement of privacy bag to (Indwelling Foley Catheter) catheter drainage bag and catheter stabilizer every shift. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of Resident 106's Foley Catheter Care Plan, dated 6/4/24, indicated that Resident 106 had a Foley catheter for neurogenic bladder (a name given to a number of urinary conditions in residents who lack bladder control due to a brain, spinal cord or nerve problem) and was at risk for pain and bleeding. The care plan interventions included were to monitor catheter and change bag as needed, to monitor for any adverse changes such as fever, no urine output and report to physician immediately and to monitor urine for sediments (the matter that settles to the bottom of a liquid), odor, blood, cloudiness, and amount. During an interview on 7/18/24 at 8:29 AM with Licensed Vocational Nurse 3 (LVN 3), LVN 3 stated that Foley catheters are checked every shift and documented on the resident's Treatment Administration Record (TAR). During an interview on 7/18/24 at 8:32 AM with LVN 4, LVN 4 stated that residents' Foley catheters are checked every shift and documented on the resident's TAR. LVN 4 also stated that when they look at a resident's Foley catheter, they are looking to see what color the urine is, if it is cloudy or if it has any sediments. LVN 4 further stated that if they noticed anything out of the ordinary with a resident's Foley catheter, they would first assess the resident's status, call the physician and change the resident's Foley catheter or flush (helps to remove any debris that may be in the bladder, which can lead to blocking the catheter, preventing it from draining) it if there is an order. During a concurrent record review of Resident 106's TAR, dated 7/2024 and interview with LVN 3 on 7/18/24 at 8:43 AM, Resident 106's TAR indicated missing documentation that the resident's Foley catheter was monitored for drainage, redness, bleeding, irritation, crusting or pain at the catheter urethral junction during catheter care on the following dates and shifts: a. 7/2/24 for the second shift b. 7/7/24 for the third shift c. 7/15/24 for the second shift d. 7/16/24 for the second shift There was also missing documentation indicating that the placement of privacy bag to the catheter drainage bag and catheter stabilizer was being monitored on the following dates and shifts: a. 7/2/24 for the second shift b. 7/7/24 for the third shift c. 7/15/24 for the second shift d. 7/16/24 on the second shift LVN 3 verified that documentation on those days and shifts were missing and stated that because there was no documentation, it means it was not monitored for that shift. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent record review of Resident 106's Foley Catheter Care Plan, dated 6/4/24 and interview with the Director of Nursing (DON) on 7/19/24 at 9:35 AM, the DON stated Resident 106's Foley Catheter Care Plan indicated to monitor for any adverse changes such as fever, no urine output and report to physician immediately. Staff interventions also included were to monitor urine for sediments, odor, blood, cloudiness, and amount. The DON stated that it was important to monitor because it could lead to the resident developing an infection such as a UTI. The DON also stated that if there was no signature on the resident's TAR for a monitoring order then that means it was not monitored. The DON stated it was important to document accurately because if it was not documented, it was not done. 45099 2. A review of Resident 103's Admission Record indicated the resident was initially admitted to the facility on [DATE] and readmitted on [DATE] with a diagnosis of epilepsy (brain disorder marked by sudden recurrent episodes of sensory disturbance, loss of consciousness, or convulsions, associated with abnormal electrical activity in the brain) (a disorder of the nervous system that can cause people to suddenly become unconscious and to have violent, uncontrolled movements of the body). A review of Resident 103's Physician's Order, dated 5/30/24 at 9:13 AM, indicated Resident 103's suprapubic stoma site was to be cleaned with normal saline (NS, salt solution), pat dry and then covered with dry dressing everyday shift. A review of Resident 103's MDS dated [DATE], indicated Resident 103 had moderate impairment in cognitive skills for daily decision making. The MDS also indicated Resident 103 required partial assistance (helper does less than half the effort) with toileting hygiene and shower and required supervision (helper provides verbal cues) with oral and personal hygiene, lower body dressing, and putting on/taking off footwear. During a concurrent observation and interview on 7/16/24 at 8:56 AM, Resident 103's was seen scratching his lower abdominal area and stated it was itchy. Resident 103 was observed with suprapubic catheter and a dressing that was soiled and dirty. Resident 103 stated the dressing was last changed four (4) days ago and the suprapubic catheter site has not been cleaned. During a concurrent interview and record review on 7/18/24 at 10:31 AM, the wound care Treatment Administration Record (TAR) indicated that the suprapubic stoma site was dressed daily and was last signed by Treatment Nurse 1 (TN 1) on 7/16/24 and 7/17/24. TN 1 stated the last suprapubic stoma site dressing change on Resident 103 was on 7/12/24. TN 1 further stated the suprapubic stoma site dressing should be done daily to keep the Resident 103 from getting an infection on the site. During an interview on 7/18/24 at 11:04 AM, the licensed Vocational Nurse 3 (LVN 3) stated suprapubic stoma dressing should be changed daily and as needed to prevent infection to the stoma and prevent skin breakdown. During an interview on 7/18/24 at 2:52 PM, the Infection Prevention Nurse (IPN) stated Resident 103's suprapubic stoma site needed to be cleaned to prevent the risk for infection on the site. (continued on next page)

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	555908	A. Building B. Wing	07/19/2024

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review on 7/18/24 at 3:07 PM, LVN 3 confirmed there was no Care Plan related to the daily dressing change for the suprapubic stoma. LVN 3 stated the Care Plan should be updated so that the staff will be reminded that they should be doing the dressing as ordered. LVN 3 further stated the Care Plan helped serve as a communication tool for the nurses for the services that needed to be provided to the resident. A review of the facility's Policy and Procedure (P&P) titled, Foley Catheter Care, dated 2019, indicated its purpose was to prevent infection of the resident's urinary tract and to report any signs or symptoms of infection, suspected obstruction/retention, or significantly reduced output to the attending physician. A review of the facility's P&P titled, Charting and Documentation, reviewed 5/2024, indicated, Documentation in the medical record will be objective (not opinionated or speculative), complete, and accurate.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45099 Based on observation, interview, and record review, the facility failed to ensure the resident received the two (2) liters (unit of volume used for measuring capacity of liquids) of water required to receive daily and to accurately record fluid intake for one (1) of two (2) sampled residents (Resident 112) as indicated in the physician's order and in accordance with the facility's policy. This deficient practice could potentially result to insufficient fluids received daily affecting Resident 112's overall health and well-being. Findings: A review of Resident 112's Admission Record indicated the resident admitted to the facility on [DATE] with a diagnosis of hyperosmolality (condition wherein blood has high concentration of sodium (salt), glucose and other substance) and hypernatremia (a condition in which the blood has a high concentration of salt. A Review of Resident 112's History and Physical (H&P), dated 11/11/23, indicated Resident 112 had the capacity to understand and make decisions. A review of Resident 112's Physicians Order, dated 4/9/24 at 5:30 PM, indicated that Resident 112 was to drink at least 2 liters of water daily and to encourage to drink electrolyte (chemicals that conduct electricity when dissolved in water. They regulate nerve and muscle function, hydrate the body, balance blood acidity and pressure, and help rebuild damaged tissue). A review of Resident 112's Minimum Data Set (MDS, standardized assessment and care screening tool), dated 5/19/24, indicated Resident 112 had moderate impairment in cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decision making. The MDS also indicated Resident 112 was dependent (helper does all the effort) with toileting hygiene, shower, upper and lower body dressing, and putting on/taking off footwear. The MDS further indicated Resident 112 required substantial/maximal assistance (helper does more than half the effort) with oral and personal hygiene and required partial assistance (helper does less than half the effort) with eating. A review of Resident 112's Care Plan for abnormal laboratory values related to chronic kidney disease (CKD, when the kidney has become damaged over time and have a hard time doing all their important jobs) revised on 6/1/24 did not include an intervention for the resident to drink at least 2 liter of water daily and encourage to drink electrolytes. A review of a facility form titled, Certified Nursing Assistant (CNA) Daily Charting Form, for the month of July 2024 did not indicate the amount of fluids received by Resident 112 daily. Resident 112's record only indicated if fluids was offered or not. During an interview on 7/16/24 at 9:03 AM, Resident 112's Responsible Party 1 (RP 1) who was in the resident's room visiting stated each time he comes by to visit his father (Resident 112) RP 1 noticed the resident was always thirsty. RP 1 also stated had never seen a nurse come by his father's room to offer Resident 1 drinks or water. (continued on next page)

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	555908	A. Building B. Wing	07/19/2024

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 7/17/24 at 12:14 PM, Resident 112 stated nobody offered him water and/ or fluids on a regular basis. During a concurrent observation and interview on 7/17/24 at 4:25 PM, Resident 112 had a pitcher full of water without any cups placed on the overbed bedside table. Resident 112 stated he only received water during meals and staff just leave the pitcher of water at the bedside but does not offer nor give it to him. Resident 112 further stated he needed the staff to put the water in the cup with a straw for him to drink and there was no cup available for him to use. Resident 112 was observed with a dry, cracked palate (the roof of the mouth separating the mouth from the nasal cavity) and tongue. Resident 112stated they (inside of mouth and tongue) felt dry. During an interview on 7/17/24 at 4:37 PM, CNA 2 stated she did not know Resident 112 was required to drink at least 2 liter of water per day. CNA 2 stated Resident 112 could get dehydrated and develop urinary tract infection (UTI, a condition in which bacteria invade and grow in the urinary tract) if the resident did not receive enough water to drink. During a concurrent interview and record review of the physician's order dated 4/9/24, on 7/17/24 at 4:56 PM, the Licensed Vocational Nurse 10 (LVN 10) stated he was not aware why Resident 112 needed 2 liter of water per day. LVN 10 stated, after reviewing Resident 112's physician's order dated 4/9/24, he now knows that the resident had on going issues with his kidney. LVN 10 then stated Resident 112's kidneys could shut down if he was not given enough fluids which could result to an electrolyte imbalance. LVN 10 further stated it would not help encourage Resident 112 to drink water if there was no cups and straws at the resident's bedside table. During an interview on 7/18/24 at 11:50 AM, the Minimum Data Set (MDS) nurse stated when the physician orders something it is usually in relation to the resident's medical condition and should be followed to minimize complications to the resident. The MDS nurse also stated the licensed nurse that received the order to give 2 liters of water to Resident 112 should have updated the care plan for abnormal laboratory values related to CKD so everyone would be aware of the new or revised plan of care for the Resident 112. The MDS nurse further stated Resident 112 should have an intake and output monitoring to have an accurate measurement of how much water the resident took to ensure compliance with what the physician ordered. During an interview on 7/18/24 at 2:44 PM, LVN 3 stated Resident 112 Resident 112 needed to be hydrated because of his kidney issues. LVN 3 also stated if the physician's order to give 2 liters of water to Resident 112 the resident's kidneys could not function properly which could potentially result to kidney failure. During an interview on 7/18/24 at 4:11 PM, CNA 10 stated they only document if the fluids was offered to the residents or not when charting on the CNA Daily Charting Form. CNA 10 also stated the amount of fluid intake was not being documented on CNA Daily Charting Form. During an interview on 7/18/24 at 4:14 PM, LVN 3 stated there should be an intake and output for Resident 112 to ensure the resident gets the correct amount of water per day as ordered. LVN 3 also stated the staff would not be able to find out if Resident 112 received the 2 liters of water per day if there was no intake and output recorded. (continued on next page)

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	555908	A. Building B. Wing	07/19/2024

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 7/19/24 at 8:39 AM, the Director of Nursing (DON) stated if Resident 112 would not receive the correct amount of water required per day places Resident 112 at risk for an abnormal blood works and could affect the resident's kidneys. A review of the facility's Policy and Procedure titled, Hydration, dated 2019, indicated its purpose was to ensure that each resident consumes adequate fluids to maintain proper hydration for optimum functioning of various body systems. The policy also indicated that residents at high risk for dehydration will have the following assessment and documentation which included care plan entry denoting risk and interventions including intake and output monitoring and assessment.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48395 Based on observation, interview, and record review the facility failed to follow their policy and procedure regarding oxygen administration for two (2) of 2 residents (Residents 7 and 129) by failing to ensure: 1. Resident 7's oxygen was at the correct ordered setting in accordance with the physician's order. This deficient practice resulted in Resident 7 not receiving the correct ordered amount of oxygen which had the potential to result in complications associated with oxygen therapy. 2. Resident 129's oxygen nasal cannula (NC, a device that delivers extra oxygen through a tube and into your nose) was changed every seven (7) days. Facility also failed to maintain a clean oxygen concentrator (a medical device that gives extra oxygen). These deficient practices had the potential for Resident 129 to develop a respiratory infection and cause complications associated with oxygen therapy. Findings: 1. A review of Resident 7's Admission Record, indicated the resident was initially admitted to the facility on [DATE] with diagnoses of metabolic encephalopathy (a problem in the brain) and chronic obstructive pulmonary disease (COPD, a common lung disease causing restricted airflow and breathing problems). A review of Resident 7's History and Physical Examination (H&P), dated 4/29/24 , H&P indicated the resident does not have the capacity to understand or make decisions. A review of Resident 7's Minimum Data Set (MDS, a standardized resident assessment care screening tool), dated 5/4/24, indicated the resident was severely impaired (never/rarely made decisions) with cognitive (ability to think, remember, and reason) skills for daily decision making. Resident 7 was dependent (helper does all of the effort; resident does none of the effort to complete the activity) with rolling from left to right in bed, going from sitting to lying down and from lying down to sitting on the side of the bed, with upper and lower dressing (how resident puts on, fastens and takes off all items of clothing) and personal hygiene. A review of Resident 7's Order Summary Report, dated 7/18/24, indicated a physician's order on 6/19/24 to Administer oxygen (O2) at 2 to three (3) liters per minute (LPM, a measurement of velocity at which air flows) by (via) nasal cannula, may titrate (adjust) oxygen flow to 2 to four (4) LPM to keep O2 saturations (a measure of how much oxygen is in your blood) equal or more than 92%. Monitor oxygen saturation with oxygen use. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555908	A. Building B. Wing	07/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of Resident 7's Respiratory Care Plan, dated 5/6/24, indicated Resident 7 had a potential for respiratory distress related to diagnosis of COPD/Asthma (a chronic disease in which the airways in the lungs become narrowed and swollen making it difficult to breathe), respiratory failure (a condition in which your blood doesn't have enough oxygen or has too much carbon dioxide), pneumonia (PNA, an infection in one or both of the lungs caused by bacteria, viruses or fungi). Staff interventions included were to administer oxygen at 2 to 4 LPM via NC to five (5) to ten (10) LPM via oxygen mask to reach O2 saturation equal or more than 92% as needed for shortness of breath (SOB). During an observation on 7/16/24 at 4:29 PM in Resident 7's room, Resident 7's oxygen was observed to be set at 5 LPM. During an observation on 7/16/24 at 4:31 PM in Resident 7's room, Resident 7's oxygen was observed to be set at 5 LPM. A review of Resident 7's O2 Saturation Summary dated 1/26/24 to 7/19/24, indicated Resident 7's O2 saturation on 7/16/24 at 12:18 AM was 95% on oxygen via NC and their O2 saturation on 7/16/24 at 2:22 PM was 95% on oxygen via NC. The record did not indicate how much oxygen Resident 7 was on or whether the amount of oxygen administered to the resident was titrated. During a concurrent record review of Resident 7's Order Summary Report, dated 7/18/24, and interview on 7/18/24 at 9:35 AM with Licensed Vocational Nurse 2 (LVN 2), LVN 2 verified Resident 7's Order Summary Report indicated an order for resident to have oxygen at 2 to 3 liters per minute via nasal cannula, may titrate oxygen flow to 2 to 4 LPM to keep O2 saturations equal or more than 92%. LVN 2 stated, The resident's oxygen is checked every shift and the resident's oxygen setting being at 5 LPM on 7/16/24 means the physician's order was not being followed. During a concurrent observation in Resident 7's room and interview with LVN 2 on 7/16/24 at 8:10 AM, LVN 2 stated Resident 7's oxygen was set to 5 LPM. During a concurrent record review of Resident 7's Order Summary Report, dated 7/18/24, and interview on 7/19/24 at 9:37 AM with the Director of Nursing (DON). The DON verified Resident 7's Order Summary Report indicated an order for resident to have oxygen at 2 to 3 liters per minute via nasal cannula, may titrate oxygen flow to 2 to 4 LPM to keep O2 saturations equal or more than 92%. The DON stated that the resident's O2 setting should be checked every shift. The DON added that staff should look at the physician's order and compare it with the O2 setting on the oxygen concentrator. The DON stated that the Resident 7's O2 being set at 5 LPM means the order was not being followed. A review of the facility's Policy and Procedure (P&P) titled, Oxygen Administration dated 2019, the P&P indicated its purpose was to provide additional oxygen to residents and to provide guidelines for oxygen administration and indicated under the procedure to: Verify Physician's order. Turn on the oxygen on the prescribed amount. Adjust the oxygen delivery device so that it is comfortable for the resident and the proper flow of oxygen is being administered. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	44636 2. A review of Resident 129's Admission Record indicated Resident 129 was admitted to the facility on [DATE], with diagnoses of metabolic encephalopathy (abnormalities of water, electrolytes, vitamins, and other chemicals that adversely affect the brain function), sepsis (a serious condition resulting from the presence of harmful microorganisms in the blood), and anxiety disorder (persistent and excessive worry that interferes with daily activities). A review of Resident 129's MDS, dated [DATE], indicated Resident 129's cognitive skills for daily decision making were severely impaired. The MDS indicated Resident 129 was dependent for oral hygiene, toileting hygiene, shower/bathe self, upper and lower body dressing, personal hygiene, roll left and right, and lying to sitting on side of bed. The MDS also indicated sit to stand, chair/bed-to chair transfer, toilet transfer, and tub/shower transfer were not attempted due to medical condition or safety concerns for Resident 129. The MDS indicated Resident 129 received oxygen therapy. A review of Resident 129's Physician Order Summary Report, dated 5/29/24, indicated as follows: - Change the humidifier and oxygen tubing (nasal cannula or oxygen mask) every night shift every Sunday. - Change humidifier and oxygen tubing (nasal cannula or oxygen mask) as needed for soiling, malfunctioning. - Administer oxygen at 2 to 3 LPM via nasal cannula (NC, device used to deliver supplemental oxygen placed directly on a resident's nostril). May titrate oxygen flow to 2 to 4 LPM to keep oxygen saturations (SpO2, measures how much oxygen is carried by the hemoglobin [Hgb- a protein in red blood cells that carries oxygen to the body's organs and tissues and transports carbon dioxide from your organs and tissues back to the lungs] in your blood or how well a person is breathing) equal or more than 92%. A review of Resident 129's Care Plan, initiated 6/2/24, indicated Resident 129 had sepsis and had the potential for respiratory distress. The care plan interventions included were to administer oxygen at 2 to 4 liters per minute (LPM, flow of oxygen) via NC to 5 to 10 LPM via oxygen mask to reach oxygen saturations equal or more than 92% as needed for shortness of breath, encourage deep breathing, and monitor abnormal breathing patterns and implement interventions as needed/ordered. During an observation on 7/16/24 at 9:02 AM in Resident 129's room, Resident 129's NC tubing and humidifier were not labeled and dated. Resident 129's oxygen concentrator had a whitish stain drop and white spots splattered on the device. During a concurrent observation in Resident 129's room and interview with LVN 11 on 7/16/24 at 9:50 PM, LVN 11 stated Resident 129's NC tubing and humidifier were not dated. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 7/18/24 at 10:21 AM with the Infection Prevention Nurse (IPN), IPN stated the facility's policy was to change the NC every seven (7) days. IPN stated the licensed nurses needed to label the NC tubing to indicate when it was changed. IPN stated when the licensed nurses do not label the NC tubing, it will not be known when the tubing was last changed. IPN stated the tubing needed to be changed every 7 days to ensure the tubing was clean. IPN stated, The only thing I can think of is when the nasal cannula is not changed every 7 days is that it's not getting enough for the rate of oxygen. IPN stated when the NC tubing was used longer than 7 days, there was a possibility to result in change of condition such as a drop in oxygen for the resident since the tubing was clogged, dirty, or kinked. During an interview on 7/18/24 at 11:01 AM with the Infection Prevention Nurse (IPN), IPN stated the residents' oxygen concentrators should be clean and properly functioning. IPN stated the residents should be provided with clean equipment. IPN stated she had conducted in-services to the staff to maintain clean equipment. IPN stated the importance to provided clean equipment to residents was an essential aspect of their care. During a concurrent observation in Resident 129's room and interview with IPN on 7/19/24 at 11:08 AM, IPN stated there was a white stain about one and a half inch in size on Resident 129's oxygen concentrator. IPN stated Resident 129's oxygen concentrator needed to be changed. During an interview on 7/19/24 at 9:17 AM with Registered Nurse 1 (RN 1), RN 1 stated the humidifier and NC tubing needed to be labeled with the date when used. RN 1 stated it was unknown how long the unlabeled humidifier and tubing had been used since they were not dated. RN 1 stated prolonged use of the humidifier and tubing could result in bacterial growth since the NC tubing was inserted into the residents' mucous membranes. RN 1 stated the humidifier contained water and once the humidifier was opened, this could result in bacterial growth. RN 1 stated the continued used of the opened humidifier and tubing could lead to the residents getting an infection. RN 1 stated every nurse should know bacteria could grow in the NC tubing and humidifier after prolonged use. During a concurrent review of the oxygen administration policy and interview on 7/19/24 at 11:08 AM with the DON, the DON stated the policy and procedure did not include for the humidifier to be changed and dated every 7 days, and tubing to be dated. The DON stated the policy should have included for the humidifier and tubing to be changed and dated every 7 days in the policy. The DON stated the accumulation of secretions could potentially impede oxygen flow and cause an infection to the residents after use of the NC tubing and humidifier longer than 7 days. A review of the facility's Policy and Procedure titled, Oxygen Administration, dated 2019, indicated to change the oxygen mask or nasal cannula every 7 days. A review of the facility's undated Policy and Procedure titled, Cleaning and Disinfection of Resident-Care Items and Equipment, indicated Resident-care equipment, including reusable items and durable medical equipment will be cleaned and disinfected according to current Centers for Disease Control and Prevention (CDC) recommendations for disinfection and the Occupational Safety and Health Administration (OSHA) Bloodborne Pathogens Standard.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45099 Based on observation, interview, and record review, the facility failed to follow the physicians order for one (1) of five (5) sampled residents (Resident 124) in accordance with the facility policy by failing to check Resident 124's heart rate prior to administering metoprolol (medication to treat high blood pressure (the force of blood pushing against the walls of your arteries), long term chest pain and heart failure (when the heart muscle does not pump blood as well as it should). This deficient practice had the potential for Resident 124 to experience adverse consequences (undesirable effect) or events such as bradycardia (slow heart rate). Findings: A review of Resident 124's Admission Record indicated the resident was admitted to the facility on [DATE] and readmitted on [DATE] with a diagnosis that included Parkinson's disease (a brain disorder that causes unintended or uncontrollable movements, such as shaking, stiffness, and difficulty with balance and coordination). A review of Resident 1's History and Physical (H&P), dated 4/15/24, indicated Resident 124 has the capacity to understand and make decisions. A review of Resident 124's Minimum Data Set (MDS, standardized assessment and care screening tool), MDS dated [DATE], indicated Resident 124 had an intact cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decision making. The MDS also indicated Resident 124 required substantial/maximal assistance (helper does more than half the effort) with shower, lower body dressing and putting on/taking off footwear and required partial assistance (helper does less than half the effort) with toileting hygiene. The MDS further indicated Resident 124 required supervision (helper provides verbal cues) with oral and personal hygiene, and upper body dressing. A review of Resident 124's Physicians Order, dated 6/19/24 at 7:58 AM, indicated to give metoprolol succinate capsule ER (extended release) 200 milligram (mg, a unit of measurement) once a day and to hold for Systolic Blood Pressure (SBP , the first number in the blood pressure reading which measures the pressure in the arteries when the heart beats) less than 110 and pulse rate less than 60. During a concurrent medication administration observation and interview on 7/18/24 at 8:30 AM, Licensed Vocational Nurse 2 (LVN 2) did not check Resident 124's heart rate prior to administering metoprolol succinate capsule to Resident 124. LVN 2 stated she only needed to check Resident 124's blood pressure and confirmed she did not check the residents heart rate. LVN 2 stated, I should have checked the resident's heart rate because if it was under 60, I would have to hold the metoprolol to prevent the heart rate from lowering even more, which could potentially cause the resident to faint and pass out. During an interview on 7/18/24 at 3:28 PM, the MDS nurse stated the physician's instruction to check the heart rate prior to administering the metoprolol should be followed to avoid risks of any complications. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 7/19/24 at 8:17 AM, the Director of Nursing (DON) stated the licensed staff should follow the physicians order to check Resident 124's heart rate before administering metoprolol to prevent the risks of any potential adverse effects. A review of the facility's Policy and Procedure titled, Administering Medications, dated 10/1/23, indicated that the medications shall be administered as prescribed. The policy also indicated that medications must be administered in accordance with the orders.

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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. 47362 Based on observation, interview, and record review, the facility failed to follow proper food handling practices in accordance with the facility's policy and procedure by: 1. Facility failed to properly seal a container of chicken soup base and wheat flour. 2. Facility failed to ensure the refrigerator designated for resident's food items brought form outside was kept clean. These deficient practices had the potential to result in pathogen (germ) exposure to residents, which could place the residents at risk for developing foodborne illness (food poisoning) with symptoms including upset stomach, stomach cramps, nausea, vomiting, diarrhea, and fever, which can lead to other serious medical complications and hospitalization . Findings: During concurrent observation in the kitchen and interview on 7/16/24 at 7:52 AM with the Dietary Supervisor (DSS), DSS stated the clear plastic container of chicken soup base and wheat flour was not sealed properly. During interview on 7/18/24 at 8 AM with the Dietary Staff (DS 1), DS 1 stated all containers are supposed to be closed or sealed properly to prevent cross contamination. DS 1 also stated insects like bugs can get inside the container if not properly closed and can cause sickness to residents. During concurrent observation in the employee's breakroom and interview on 7/18/24 at 7:05 AM with the Infection Preventionist (IP), IP stated the refrigerator designated for resident's food items brought form outside was dirty. IP added, the refrigerator door has brownish to blackish crusted food residue on the upper shelf and there was spilled milk at the bottom of the refrigerator behind and on the vegetable crisper. During interview on 7/19/24 at 11:23 AM with the IP, IP stated all refrigerator units should be kept clean and in good condition to prevent food contamination that might cause sickness to residents. During interview on 7/19/24 at 3:31 PM with the Director of Nursing (DON), the DON stated all containers in the kitchen should be closed/ sealed properly to prevent food contamination. The DON also stated resident's refrigerator should be kept clean all the time and it is not acceptable to have dirty refrigerator. A review of the facility's Policy and Procedure (P&P) titled, Food Production and Food Safety, dated 2019, indicated Refrigerator food storage: all refrigerator unit will be kept clean and in good working condition at all times. (continued on next page)

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	555908	A. Building B. Wing	07/19/2024

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the facility's P&P titled, Food Storage, dated 2019, indicated sufficient storage facilities will be provided to keep foods safe, wholesome, and appetizing. Food will be stored in an area that is clean, dry, and free from contaminants. Plastic containers with tight fitting covers must be used for storing grain product, sugar, dried vegetables, and broken lots of bulk foods.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48395 Based on observation, interview and record review, the facility failed to ensure that Restorative Nursing Assistant (RNA, nursing interventions that promote the resident's ability to adapt and adjust to living as independently and safely as possible) services were documented timely and accurately for one (1) of 26 sampled residents (Resident 106). This failure resulted in the facility not documenting RNA services for Resident 106 timely and accurately as indicated in the facility policy. Findings: A review of Resident 106's Admission Record, indicated the resident was initially admitted to the facility on [DATE] with diagnoses of generalized (spread or extended throughout the body) weakness and neuromuscular dysfunction of the bladder (when the nerves and muscles don't work together well and as a result the bladder may not fill or empty correctly). A review of Resident 106's History and Physical Examination (H&P), dated 5/31/24, indicated the resident has the capacity to understand and make decisions. A review of Resident 106's Minimum Data Set (MDS, a standardized resident assessment care screening tool), dated 6/8/24, indicated the resident was moderately impaired with cognitive (ability to think, remember, and reason) skills for daily decision making. Resident 106 was dependent (helper does all of the effort and resident does none of the effort to complete the activity) with toilet transfers, going from a lying to sitting on the side of the bed, rolling left and right in bed, upper and lower body dressing (how a resident puts on, fastens and takes off all items of clothing), and eating. A review of Resident 106's Order Summary Report dated 7/18/24, indicated an order placed on 7/3/24 to start on 7/4/24 for Resident 106 to have RNA services for passive range of motion (PROM, a space in which a part of one's body can move when someone or something is creating the movement) for bilateral (both) lower extremities (legs/feet) every day (QD) five (5) days a week or as tolerated once a day and for bilateral upper extremities (arms/hands) active-assisted range of motion (AAROM, when the joint receives partial assistance from an outside force) QD 5 times a week as tolerated once a day. A review of Resident 106's RNA Program Care Plan, dated 7/3/24, the RNA Program Care Plan indicated Resident 106 was at risk for decrease in range of motion (ROM) to joint, at risk for contractures and at risk for loss of motion. The care plan interventions included to provide gentle active/passive range of motion exercises as ordered, for the resident to have RNA program as ordered as well as to have RNA for bilateral upper extremity AAROM QD 5 times a week or as tolerated and PROM to bilateral lower extremities QD 5 times a week or as tolerated. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident 106's RNA Referral Form dated 7/4/24, the RNA Referral Form indicated the reason for referral was to prevent contractures and to maintain ROM/improve ROM with the approaches being AAROM exercises for the right and left upper extremities and PROM exercises for the right and left lower extremities. The form also indicated the order for these exercises to be done QD 5 times a week or as tolerated and was signed by the referring therapist and by the RNA who received the referral on 7/5/2024. During a concurrent interview and record review on 7/18/24 at 2:43 PM with RNA 1, the two RNA services binders dated July 2024 and Resident 106's Order Summary Report dated 7/18/24 were reviewed. No RNA services log for Resident 106 was found in either of the two RNA services binders for July 2024 and Resident 106's Order Summary Report indicated an order dated 7/3/24 for the Resident to start RNA services on 7/4/24. RNA 1 stated there is no documentation or log of RNA being done for Resident 106 and verified that there was an order for Resident 106 to start RNA on 7/4/24. During a concurrent observation and interview on 7/18/24 at 2:49 PM with RNA 2, RNA 2 was observed signing the RNA services log form for Resident 106. RNA 2 stated that he was signing the resident's RNA services log form at that moment and stated that he had signed the dates from 7/4/24 to 7/12/24. RNA 2 stated that he knew there was an order for Resident 106 to start RNA services on 7/4/24 and that he had signed off on the RNA services referral form for the resident but forgot to obtain a log for the resident and failed to document that the services were done for the past two weeks (from 7/4/24 to 7/12/24). RNA 2 further stated that to show that RNA services were provided to a resident, he should have documented it on the resident's RNA service log form and that the point of documentation is to show that a task was done. During an interview on 7/18/24 at 3:10 PM with Director of Rehab (DOR), DOR stated once residents are discharged from physical therapy, they will write an order for RNA services and once the nurses confirm the order, they will have the RNA sign off on receiving the resident's order and referral form and then hand over a copy of the resident's RNA services log which is also referred to as the Medication Administration Record (MAR). DOR stated if there is no log for the resident's RNA services, then the RNA should either ask for one to be printed out from someone in physical therapy or notify their charge nurse. DOR also stated the RNA services log form or MAR is where the RNAs sign their daily charting by initialing under the specific date which indicates that they have seen and perform the RNA service for the resident on those days. DOR further stated if the resident's RNA services log form is not filled out or initialed or is missing from the RNA services binder, then it means those services did not happen. During an interview on 7/18/24 at 3:18 PM with Director of Nursing (DON), the DON stated once a task is done, it should be documented right away or right after it was completed for accuracy and to avoid any staff member from forgetting what may have happened if they were to chart at a later time. The DON stated it is not acceptable to be signing off on services performed for a resident two weeks later as they will not know if there were any significant changes with the resident's condition. A review of the facility's Policy and Procedure (P&P) titled, Charting and Documentation, reviewed 5/2024, the P&P indicated, Documentation in the medical record will be objective (not opinionated or speculative), complete, and accurate. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the facility's P&P titled, Activities of Daily Living (ADL; fundamental skills required to independently care for oneself such as eating, bathing and mobility) Documentation, dated 2017, the P&P indicated its purpose was to provide consistency in documentation of resident status and care given by nursing staff and the facility will ensure documentation of the care provided to the residents for completion of ADL tasks.

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44636 Based on interview and record review, the facility failed to ensure one of two sampled residents (Resident 186) had a hospice (a program that gives special care to residents who are near the end of life and have stopped treatment to cure or control their disease) comprehensive assessment for the plan of care to include the frequency of hospice staff visits. This deficient practice had the potential for Resident 186 not to receive the hospice care and services necessary to promote comfort and quality of life. Findings: A review of Resident 186's Admission Record indicated Resident 186 was initially admitted to the facility on [DATE] and readmitted on [DATE], with diagnoses of malignant neoplasm of colon (cancerous growths that affect the large intestine), cerebrovascular disease (a group of disorders that affect the blood vessels and blood supply to the brain), and hemiplegia (a condition caused by brain damage or spinal cord injury that leads to paralysis [loss of motor function in one or more muscles] on one side of the body) and hemiparesis (weakness on one side of the body) following cerebral infarction (a stroke, damage to tissue in the brain due to loss of oxygen to the area) affecting right dominant side. A review of Resident 186's Minimum Data Set (MDS, a standardized assessment and care planning tool), dated 5/28/2024, indicated Resident 186's cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decision making were intact. The MDS indicated Resident 186 had an impairment on one side of the upper extremity (shoulder, elbow, wrist, hand) and one side of the lower extremity (hip, knee, ankle, foot). The MDS indicated Resident 186 was dependent (helper does all of the effort, resident does none of the effort to complete the activity, or the assistance of two or more helpers were required for the resident to complete the activity) for toileting hygiene, shower/bathe self, upper and lower body dressing, roll left and right, and sit to lying. The MDS indicated mobility such as sit to stand, chair/bed-to-chair transfer, and toilet transfer were not attempted due to medical condition or safety concerns for Resident 186. A review of Resident 186's Physician Order Summary Report, dated 7/10/24, indicated admit to hospice on routine level of care with diagnosis of cerebrovascular disease. A review of Resident 186's care plan, initiated 7/12/24, indicated Resident 186 was on end- of- life stage under hospice. The care plan interventions were hospice nursing staff to provide visits as scheduled, hospice and facility social services to provide psychosocial support as needed and monitor for any changes in condition and report to physician as needed. A review of Resident 186's Visit Calendar and Coordination Notes for July 2024, indicated as follows: - 7/10/24: Registered Nurse 2 (RN 2) visited. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555908	A. Building B. Wing	07/19/2024

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- 7/12/24: RN 3, Health Aide (HA), Spiritual Counselor (SC), and Medical Social Worker (MSW) visited for the Interdisciplinary Team (IDT, group of healthcare professionals from diverse fields who work in a coordinated manner toward a common goal for the resident) meeting. There were no Hospice physician orders or hospice calendar (calendar to show frequency of visits from hospice staff such as licensed nurse, HA, SC and/or MSW) to indicate the frequency of visits from hospice staff (RN, HA, SC and MSW) for the month of July 2024. During a concurrent interview and record review of Resident 186's hospice documents with RN 1 on 7/19/24 at 9:33 AM, RN 1 stated the physician placed Resident 186 on hospice on 7/10/2024 when readmitted to the facility. RN 1 stated there were orders or hospice calendar to specific hospice staff visits. RN 1 stated Resident 186 received two visits on 7/10/24 and 7/12/24 from hospice. RN 1 stated there were no hospice visits from 7/13/24 to 7/19/24. RN 1 stated she was not able to tell who and when hospice staff were supposed to conduct visits for Resident 186. RN 1 stated the absence of the hospice calendar would result in Resident 186 to not receive the care he was supposed to receive from hospice. During a concurrent interview and record review of Resident 186's hospice documents with the Director of Nursing (DON) on 7/19/24 at 11:19 AM, the DON stated the hospice calendar had only been filled in for two days (7/10/24 and 7/12/24) for July 2024. The DON stated there was no order from hospice which indicated when hospice staff were supposed to visit Resident 186. The DON stated the hospice staff were required to put their name on the calendar, sign in the sign in sheet, and document in the coordination notes. The DON stated Resident 186's hospice documents did not include a sign in sheet and there was no documentation on the coordination notes for the HA and MSW/SC. The DON stated hospice visits and documentation should be included in the hospice binder since the facility and hospice were in collaboration of Resident 186's care. A review of the facility's Policy and Procedure titled, Hospice, dated 2019, indicated hospice services will be provided to those residents requesting such services upon order of the attending physicians. A review of the Hospice and Nursing Facility Services Letter of Agreement, dated 7/9/24, indicated provision of care as specified in each patient's plan of care, assignment and supervision of hospice health aids, collaboration with facility staff in delivery and updated plan of care, communication, and coordination of patient care services of facility station and hospice interdisciplinary team.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45099 Based on observation, interview, and record review, the facility failed to ensure standard infection prevention control practices (a set of practices that prevent or stop the spread of infections and or diseases in the healthcare setting) were implemented for two (2) of 26 sampled residents (Residents 10 and 57) according to the facility's policy and procedure when: 1. Licensed Vocational Nurse 8 (LVN 8) failed to disinfect (clean with a chemical, in order to destroy bacteria) the shared blood pressure cuff after obtaining Resident 10's blood pressure (pressure of circulating blood against the walls of blood vessels) reading. This deficient practice had the potential to spread infection to other residents in the facility. 2. LVN1 did not wear personal protective equipment (PPE) during medication administration to Resident 57, who had a gastrostomy tube (GT, a tube inserted through the belly that brings nutrition directly to the stomach) and was on Enhanced Barrier Precautions (EBP, refer to an infection control intervention designed to reduce transmission of multidrug-resistant organisms that employs targeted gown and glove use during high contact resident care activities). This deficient practice had the potential to contaminate Resident 57's GT site and can place the resident at risk for infection. Findings: 1. A review of Resident 10's Admission Record indicated the resident was initially admitted to the facility on [DATE] with a diagnosis of urinary tract infection (UTI, an infection that affects part of the urinary tract). A review of Resident 10's History and Physical (H&P), dated 6/20/24, indicated Resident 124 had the capacity to understand and make decisions. A review of Resident 10's Minimum Data Set (MDS, standardized assessment and care screening tool), dated 6/22/24, indicated Resident 10 had an intact cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decision making. The MDS also indicated Resident 10 was dependent (helper does all the effort) with toileting, shower, lower body dressing, and putting on/taking off footwear and required substantial/maximal assistance (helper does more than half the effort) with oral hygiene and upper body dressing. During an observation on 7/18/24 at 9:30 AM, LVN 8 was observed obtaining Resident 10's blood pressure. After LVN8 obtained Resident 10's blood pressure, LVN8 did not disinfect the blood pressure cuff. LVN 8 proceeded down the hallway attempting to enter another resident's room without disinfecting the blood pressure cuff. LVN 8 stated he should have sanitized the BP cuff after use with Resident 10 to prevent spread of any bacteria from resident to resident. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 7/19/24 at 8:20 AM, the Director of Nursing (DON) stated the BP cuff should be cleaned before and after use because it was an infection control issue. The DON also stated if the resident who used the BP cuff before had an infection, it could potentially transfer to the other resident whom the BP cuff will be used next. During an interview on 7/19/24 at 8:28 AM, the Infection Prevention Nurse (IPN) stated the BP cuff was a shared equipment so it should be disinfected before and after each resident use. The IPN also stated if a resident had an infection there was a high risk that it could pass on to other residents. A review of the undated facility's Policy and Procedure titled, Cleaning and Disinfection of Resident-Care Items and Equipment, indicated that resident care equipment, including reusable items and durable medical equipment will be cleaned and disinfected according to current Centers for Disease Control (CDC) recommendations for disinfection and the Occupational Safety and Health Administration (OSHA) Bloodborne Pathogens Standard. 45456 2. A review of Resident 57's Admission Record indicated the resident was initially admitted to the facility on [DATE] and readmitted on [DATE]. Resident 57's diagnoses included dysphagia (difficulty swallowing), Parkinson's disease (a brain disorder that causes unintended or uncontrollable movements, such as shaking, stiffness, and difficulty with balance and coordination) and metabolic encephalopathy (ME, occurs when problems with your metabolism cause brain dysfunction). A review of Resident 57's MDS, dated [DATE], indicated Resident 57 had moderately impaired cognitive (mental action or process of acquiring knowledge and understanding) skills impairment for daily decision making. Resident 57 was dependent (helper does all of the effort, Resident does none of the effort to complete the activity) in oral hygiene, toileting hygiene, shower/bathe self, upper and lower body dressing, putting on/ taking off footwear, personal hygiene, roll left and right, sit to lying, and lying to sitting on side of the bed, and chair/bed-to -chair transfer. A review of Resident 57's Order Summary Report, dated 7/9/24 indicated Enteral Feed order to administer Isosource 1.5 Cal (a calorically dense complete nutrition formula with fiber for increased calorie needs and/or limited fluid tolerance) via GT at 55 cubic centimeters (a unit of measurement per hour (cc/hour) for 20 hours via kangaroo pump (delivers continuous or intermittent feeding) to provide 1100 total cc/1650kcal in 24 hours. Start administration at 12 noon and turn off at 8 AM or until dose is completed. During a concurrent observation and interview with Resident 57's room on 7/17/24 at 4:35 PM, LVN 1 did not wear the complete PPE before administering Resident 57's medications. LVN 1 stated, I forgot to wear the gown before administering the medications to the resident. We should follow the Enhanced Barrier Precautions practices because the resident has a GT, and she is prone to infection. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent observation and interview in Resident 57's room with LVN 6 on 7/18/24 at 8:20 AM, LVN 6 was observed disconnecting Resident 57's GT connection and attaching a white tip cone connector (intended to improve patient safety and decrease the risk of medical device misconnections) to the labeled sticker attached to Resident 57's water bag flush. The cone connector was observed falling on top of the GT machine. LVN 6 left the cone connector on top of the machine hanging and exposed to open to air while LVN 6 administered medications to Resident 57. During a concurrent observation and interview in Resident 57's room with LVN 6 on 7/18/24, at 8:36 AM, LVN 6 was observed attempting to connect the white cone connector to Resident 57's GT feeding connection. LVN 6 stated, The label sticker attached on the water flush bag was not sterile and I should not have attached the GT cone connector in there. The cone connector had to be changed because I did not put it on a sterile area and if I connect the cone connector to the GT, without changing it, it can cause infection to the resident. During an interview with the DON on 7/19/24, at 9:14 AM, DON stated, We follow EBP for resident with enteral feeding, or open skin. If a resident had an open wound, the resident was high risk of transmission of infection. If the staff did not follow the EBP will have a tendency that resident will get an infection. A review of the facility's Policy and Procedure titled, Enteral Feedings - Safety Precautions, revised 2017, indicated to ensure the safe administration of enteral nutrition. Maintain strict aseptic technique at all times when working with enteral nutrition systems and formulas. A review of the facility's P&P titled, Initiating Enhanced Barrier Precaution dated 4/1/24, indicated for residents for whom EBP are indicated, EBP is employed when performing the following high-contact resident care activities: device care or use: central line, urinary catheter, feeding tube, tracheostomy/ventilator.

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that a working call system is available in each resident's bathroom and bathing area. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47362 Based on observation, interview and record review, the facility failed to ensure that the resident call system (call light- allow resident to communicate when they need assistance) for two (2) of 26 sampled residents (Residents 35 and 119) was functional for Resident 35 and within reach for Resident 119 as indicated in the facility policy. This failure had the potential to put Residents 35 and 119 at risk for experiencing a delay in receiving assistance from facility staff which could lead to a fall or accident. Findings: 1. A review of Residents 35 Admission Records indicated the facility admitted Resident 35 on 5/8/2024 with diagnosis including muscle weakness, difficulty in walking, unsteadiness on feet. A review of Resident 35's History and Physical Examination (H&P), dated 5/10/2024, indicated the resident has the capacity to understand or make decisions. A review of the Minimum Data Set (MDS, standardized care and screening tool) dated 5/17/2024, indicated Resident 35 cognition was intact (processes of thinking and reasoning) skills for daily decision making. The MDS indicated Resident 35 required setup or clean up assistance moderate assistance (helper set up or clean up; resident completes activity. Helper assists only prior to or following the activity) on eating, partial / moderate assistance (helper does less than half the effort) on toileting hygiene, shower bathe self, personal hygiene. A review of Resident 35's care plan date initiated 5/19/2024 indicated Resident 35 requires assistance in activities of daily living. Interventions maintain call light within easily reach and encourage to use call light for assistance. During concurrent observation and interview on 7/16/2024 at 4:57 PM with the certified nursing assistant (CNA 6) in Resident 35's room, CNA 6 pressed the call light button but did not light up by the door and in the nurse station. During an interview on 7/16/2024 at 5 PM with the Director of Staff Development (DSD), DSD stated the importance of call light were to alert the staff when residents needed assistance, and it prevents the resident from getting up and having a fall. The DSD also stated, if the call light was not working, the resident can get up unattended, and the resident's needs cannot be met. During interview on 7/16/2024 at 5:02 PM with the Maintenance Supervisor (MTS), MTS stated call light is important because the residents use it to call the staff if they need something like to eat, drink, need to be changed, medicine or need anything. MTS also stated, if the call light does not work the resident were not able to communicate with the staff. 48395 (continued on next page)

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	555908	A. Building B. Wing	07/19/2024

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. A review of Resident 119's Admission Record, indicated the resident was initially admitted to the facility on [DATE] with diagnoses of non-stemi (non-ST/NSTEMI) elevation myocardial infarction (a type of heart attack involving a partly blocked coronary artery that causes reduced blood flow) and cerebral infarction (damage to tissues in the brain due to loss of oxygen to the area). A review of Resident 119's H&P, dated 6/29/2024, indicated the resident does not have the capacity to understand or make decisions. A review of Resident 119's MDS, dated [DATE], indicated the resident was severely impaired (never/rarely made decision) with cognitive (ability to think, remember, and reason) skills for daily decision making. Resident 119 was dependent (helper does all of the effort; resident does none of the effort to complete the activity) with rolling left and right in bed, upper and lower body dressing (how a resident puts on, fastens, and takes off all items of clothing), personal hygiene and eating. A review of Resident 119's At Risk for Falls Care Plan, dated 3/26/2024, indicated to keep call light within easy reach. During an observation on 7/16/2024 at 9:03 AM in Resident 119's room, Resident 119 was observed asleep in bed & their call light was observed on the ground behind and to the right of their bed by the wall. During a concurrent observation and interview on 7/16/2024 at 9:08 AM with Certified Nursing Assistant 1 (CNA 1) in Resident 119's room, Resident 119's call light was observed on the ground behind and to the right of Resident 119's bed by the wall. CNA 1 stated that Resident 119's call light was on the floor and to the right of the resident's bed by the wall and that it should not be there & placed it within the resident's reach. During an observation on 7/17/2024 at 10:24 AM in Resident 119's room, Resident 119's call light was observed hanging on the wall to the right side of the resident's head of bed. During an concurrent observation and interview on 7/17/2024 at 10:28 AM with Central Supply (CS) in Resident 119's room, Resident 119's call light was observed hanging on the wall behind and to the right of the resident's head of bed. CS stated that Resident 119's call light was hanging on the wall behind and to the right of the resident's bed and stated that it should be within the resident's reach. During an interview on 7/17/2024 at 4:51 PM with Licensed Vocational Nurse 1 (LVN 1), LVN 1 stated that a resident's call light should always be readily accessible and within reach to ensure residents can notify staff that they need assistance during an emergency. During an interview on 7/19/2024 at 9:50 AM, the Director of Nursing (DON), stated that the purpose of a call light was for residents to call for help and immediately notify staff that they need assistance. The DON also stated that if the residents decided to attempt to get out of bed without assistance due to their call light not being within reach, they could be at risk for falling. (continued on next page)

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	555908	A. Building B. Wing	07/19/2024

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the facility's Policy and Procedure (P&P) titled, Call Lights, revised August 2009, indicated its purpose was to meet the resident's requests and need within an appropriate time period and to assure that the call light is within the resident's reach when in their rooms or on the toilet. A review of the facility's P&P titled, Call System, Resident, revised May 2024, indicated, Residents are provided with a means to call staff for assistance through a commutations system that directly calls a staff member or a centralized work station, with the policy interpretation and implementation stating: Each resident is provided with a means to call staff directly for assistance from his/her bed, from toileting/bathing facilities and from the floor. The resident call system remains functional at all times. If audible communication is used, the volume is maintained at an audible level that can be easily heard. If visual communication is used, the lights remain functional.

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	555908	A. Building B. Wing	07/19/2024

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45456 Based on observation, interview, and record review, the facility failed to provide a clean, safe, and sanitary environment when: 1. Food debris were observed under Resident 16's bed. 2. Used syringes were not properly disposed in the sharps container. 3. The rubber covering of two green silicon dumbbells were observed peeling off. These deficient practices had the potential to result in the spread of diseases and infection. Findings: 1. A review of Resident 16's Admission Record indicated Resident 3 was admitted to the facility on [DATE] and readmitted on [DATE]. A review of Resident 16's History and Physical (H&P, the initial clinical evaluation and examination of the resident), dated 6/5/24, indicated Resident 16 had diagnoses of multiple sclerosis (MS, a disorder of the central nervous system marked by weakness, numbness, a loss of muscle coordination, and problems with vision, speech, and bladder control), pulmonary edema (when fluid collects in the air sacs of the lungs, making it difficult to breathe), and cardiomegaly (an enlarged heart). A review of Resident 16's Minimum Data Set (MDS, a standardized assessment and care planning tool), dated 6/7/24, indicated Resident 16 had intact cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decision making. The MDS also indicated Resident 16 was dependent (helper does all the effort. Resident does none of the effort to complete the activity) in toileting hygiene, shower/ bathe self, lower body dressing, and putting on/taking off footwear, sit to lying position, roll left and right. During a concurrent observation in Resident 16's room and interview with Certified Nursing Assistant 3 (CNA 3) on 7/17/24 at, 10:09 AM, Resident 16 had food debris on the floor, under his bed. CNA 3 stated, Those were scrambled eggs on the floor and the dried brownish colored stain was probably chocolate pudding. CNA 3 stated Resident 16's floor should be cleaned up and sanitized to prevent infection and to prevent the rodents and cockroach from coming into the resident's room. During an interview with the Housekeeper 1 (HK 1) on 7/17/24 at 10:17 AM, HK 1 stated, It is important to keep the resident's room clean because it is their home and their immune system is not that strong. We have to make sure the rooms are clean to prevent residents from getting sick. During an interview with the Director of Nursing (DON) on 7/19/24 at 9:20 AM, the DON stated, Residents should feel comfortable in the facility, have TV access on TV, and a nice place to sleep and eat. It has to be clean because this is their home now. If the residents do not have a clean environment, it is not conducive for them to live in it. (continued on next page)

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	555908	A. Building B. Wing	07/19/2024

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A record review of the facility's Policy and Procedure (P&P) titled, Homelike Environment, revised on 10/2023 , indicated, The facility staff and management shall maximize, to the extent possible, the characteristics of the of the facility that reflect a personalized, homelike setting. These characteristics include clean, sanitary, and orderly environment. 47362 2. During an observation in the hallway of Station 2 on 7/16/24 at 5:05 PM, a used syringe was observed not properly disposed in the sharps container (container made for disposing of needles or syringes). The needle of the syringe was left exposed lying on the flap of the sharps container, making it accessible to residents. During an observation in the hallway of Station 2 on 7/17/24 at 8:57 AM, a used syringe was observed lying on the flap of the sharps container, making it accessible to residents. During concurrent observation in the hallway of Station 2 and interview on 7/18/24 at 4:40 PM with the Director of Staff Development (DSD), DSD stated the used syringe was not properly disposed. DSD stated improper storage of sharps was not safe for residents and staff. DSD added it was possible for the residents to pick up the used syringe and puncture themselves which may cause injury or sickness. During interview on 7/19/24 at 3:24PM with the Director of Nursing (DON), the DON stated sharps are supposed to be discarded properly for safety of staff and residents. During a review of the facility's undated P&P titled, Sharp Disposal, indicated This facility shall discard contaminated sharp into designated containers. Whoever uses contaminated sharps will discard them immediately or as soon as possible into designated containers. 3.During observation in the facility's rehabilitation room on 7/17/24 at 10:29 AM, the rubber covering of two green silicon dumbbells were observed peeling off. During concurrent observation in the facility's rehabilitation room and interview on 7/18/24 at 4:29 PM with DSD, DSD stated the rubber covering of two green dumbbell was peeling off and were not in good condition. DSD stated, Residents deserve the best equipment they need to have. During interview on 7/19/24 at 11:55 AM with the Infection Control Nurse (IPN), IPN stated the rubber covering of the green dumbbells was peeling off and were not in good condition. IPN stated this could possibly cause blisters to the residents. During a review of P&P titled, Supplies and Equipment, dated 5/2024, indicated The facility shall provide equipment's for the general use of the resident population. Equipment / rehab supplies shall be readily available so that the department personnel can perform necessary tasks. This equipment must be in good condition.