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	07/24/2025

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

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. (continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to promote dignity and respect for one of 30 sampled residents (Resident 115) when Certified Nurse Assistant 5 (CNA 5) was observed standing above Resident 115's eye level while assisting the resident during mealtime on 7/21/2025. This deficient practice had the potential to affect Resident 115's self-esteem and self-worth and violate the resident's right to be treated with dignity. During a review of Resident 115's admission Record, the admission Record indicated the resident was originally admitted to the facility on [DATE], with diagnosis of dementia (a progressive state of decline in mental abilities), Parkinson's disease (a progressive disease of the nervous system marked by tremor, muscular rigidity, and slow, imprecise movements) and quadriplegia (paralysis from the neck down, including legs, and arms, usually due to a spinal cord injury). During a review of Resident 115's Minimum Data Set (MDS- a resident assessment tool), dated 5/28/2025, indicated Resident 115's cognitive (ability to think and reason) skills for daily decision making were modified independence (some difficulty in situations only). The MDS indicated Resident 115 required partial/moderate assistance (helper does less than half the effort) with eating, oral hygiene, upper body dressing and personal hygiene. The MDS indicated Resident 115 was dependent (helper does all the effort) with toileting hygiene, shower, lower body dressing and putting off footwear. During a review of Resident 115's care plan that focuses on Resident 115 requires assistance in Activities of Daily Living (ADLs-activities such as bathing, dressing and toileting a person performs daily), initiated on 2/14/2025, the Care Plan indicated the staff interventions included to assist with meals as needed. During an observation on 7/21/2025 7:44 AM in Resident 115's room, CNA 4 was observed standing on the right side of Resident 115's bed and above Resident 115's eye level while feeding the resident's breakfast meal. RN 1 was observed standing in front of Resident 115's bed and was not observed informing CNA 5 to get a chair or reposition Resident 115's bed higher for them to have an eye level. During an interview on 7/22/2025 at 2:14 PM with Restorative Nurse Assistant 1 (RNA 1), RNA 1 stated staff need to maintain at the resident's eye level, talk to the residents, and tell them what food they are giving when assisting the resident with feeding. During an interview on 7/22/2025 at 2:56 PM with Certified Nurse Assistant 4 (CNA 4), CNA 4 stated staff need to sit down and be at eye level with the residents to establish rapport and to show respect. CNA 4 stated, when assisting residents with meals, staff should be at the resident's eye level, and looking down at a resident is showing no respect. CNA 4 stated nurses need to sit down or position the resident's bed higher to maintain eye level between CNA and residents. During an interview on 7/23/2025 at 4:02 AM with MDS Nurse (MDSN), MDSN stated residents who need assistance during meals should be treated with respect and dignity. MDSN stated not standing above the resident's eye level while assisting with meals should be practiced. MDSN stated CNA 5 standing while assisting Resident 115 with breakfast meal was not good practice, and RN 1 who was in the room and standing in front of Resident 115 should have called out and corrected CNA 5's wrong practice. During a review of the facility's undated policy and procedure (P&P) titled, Resident Dignity and Personal Property, reviewed in April 2023, indicated The facility provides care for residents in a manner that respects and enhances each resident's dignity, individuality, and right to personal privacy. The P&P also indicated Dignity means that when interacting with residents, staff carries out activities that assist the resident in maintaining and enhancing his or her self-esteem and self-worth.

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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 - Some	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure a resident's call device (an alerting device for nurses or other nursing personnel to assist a patient when in need) was maintained within easy reach for two (2) of four (4) sampled residents (Resident 76, and Resident 120). This deficient practice had the potential to cause a delay in resident care for Resident 76 and Resident 120's resulting in unmet needs. 1. During a review of Resident 76's admission Record, the admission Record indicated Resident 76 was admitted to the facility on [DATE], and readmitted on [DATE], with diagnoses that included encephalopathy (a broad term for any brain disease that alters brain function or structure), other cerebral palsy (a group of neurological disorders that appear in early childhood and affect movement and muscle coordination), contracture of left and right hand (the shortening and tightening of the tissues in the hand, causing fingers to bend or curl inwards, often impacting daily activities). During a review of Resident 76's Minimum Data Set (MDS- a resident assessment tool), dated 5/15/2025, indicated Resident 76 had no impairment for cognitive skills (the function of the brain uses to think, pay attention, process information, and remember things)[MR1] he is able to make his own daily decision making, Resident 76 was able to follow commands. Resident 76 was dependent on oral hygiene, toileting hygiene, personal hygiene, shower/bathe self, upper and lower body dressing, change of position, and transfer. During an observation on 7/21/2025 at 9 AM in Resident 76's room, Resident 76's bilateral hands were contracted. Resident 76's call pad (an alternative to a standard call button or cord, especially for residents with difficulty with fine motor skills or gripping objects due to their contractures) was placed on the resident's right-side rail and it was hanging below his bed. During a concurrent observation in Resident 76's room and interview on 7/21/2025 at 9:03 AM with Certified Nurse Assistant 1 (CNA 1), CNA1 stated the call pad was out of Resident 76's reach and was supposed to be near Resident 76's chest area due to resident's contracture on his hands. CNA1 stated this will ensure Resident 76 can receive the care and services timely and to ensure his safety. During an interview on 7/21/2025 at 12:50 PM with Licensed Vocational Nurse 2 (LVN 2), LVN 2 stated the call pad device was supposed to be placed within Resident 76's reach for easy access and minimal movement so that the resident can get the services in a timely manner. 2. During a review of Resident 120's admission Record, the admission Record indicated Resident 120 was admitted to the facility on [DATE], readmitted on [DATE], with diagnoses that included epilepsy (neurological disorder characterized by recurring seizures), dysphagia, oropharyngeal phase (a term that describes swallowing problems occurring in the mouth and/or the throat, this is most commonly result from impaired muscle function, sensory changes, or growths and obstructions in the mouth or throat), and Alzheimer's disease (a progressive brain disorder that gradually destroys memory and thinking skills). During a review of Resident 120's MDS, dated [DATE], Resident 120 had severe impairment for cognitive skills for daily decision making. Resident 120 was dependent on toileting hygiene, shower/bathe self, upper and lower body dressing, change of position, and transfer. Resident 120 needed substantial/maximal assistance (helpers do more than half the effort) for her oral hygiene and personal hygiene. During an observation in Resident 120's room on 7/21/2025 at 9:45 AM, Resident 120's call pad device was on the floor, near her left side to the head of bed area. During a concurrent observation in Resident 120's room and interview on 7/21/2025 at 9:47 AM with LVN 2, LVN 2 stated the call pad device was on the floor and was supposed to be within Resident 120's easy reach so the resident can receive the care and services timely and to ensure her safety. During a review of the facility's Policy and Procedure titled, Call light, revised 5/2023, the Policy and Procedure indicated The purpose of this procedure is to respond to the residents' requests and needs.1. When the resident is in bed or confined to a chair be sure the call light is within easy reach of the resident.2. Some residents may not be able to use their call light. Be sure you check these residents frequently.

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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** Based on observation, interview, and record review, the facility failed to ensure residents were provided with a homelike environment for one of one sample resident (Residents 139) for the environment care area by failing to provide bed linen that was damaged with multiple small holes. This deficient practice had the potential to negatively affect the residents' quality of life. During a review of Resident 139's admission Record indicated Resident 139 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included chronic obstructive pulmonary disease (a progressive lung disease that makes it difficult to breathe), type 2 diabetes mellitus with diabetic chronic kidney disease (a chronic condition that happens when you have persistently high blood sugar levels. Insulin resistance is the main cause, and it results in a condition where the kidneys are damaged and can't function properly), muscle weakness (a reduced ability of one or more muscles to generate force, making it harder to perform tasks that require strength). During a review of Resident 139's Minimum Data Set (CNA3S- a mandated resident assessment tool), dated 5/15/2025, indicated Resident 139 had no impairment for cognitive skills (the function of the brain uses to think, pay attention, process information, and remember things) he is able to make his own daily decision making, Resident 139 was able to follow commands. Resident 139 needed substantial/maximal assistance (helper does more than half the effort. Helper lifts or holds trunk or limbs but provides more than half the effort) in toilet hygiene, shower/ bathe self, lower body dressing, and putting on/taking off footwear. He needs partial or moderate assistant, (helper does less than half the effort) with the eating, oral hygiene and personal hygiene. During an observation of Resident 139's room on 7/22/2025 at 2:18 PM, Resident 139's bed sheet was observed having over thirty small holes near the bottom of the sheet (feet area). During an interview with Resident 139 on 7/22/2025 at 2:20 PM in his room, Resident 139 stated he does not like his damaged bed sheet, and it made him feel uncomfortable. During an interview with Certified Nursing Assistant (CNA3) on 7/22/2025 at 2:43 PM, CNA3 stated the damaged and multiple small holes for the bed sheet be uncomfortable against the resident's skin and can cause low self-esteem to the residents. CNA3 stated this is not a homelike environment for the residents. CNA3 stated the residents like it when everything in their rooms is clean, with no damage and in good condition. During an interview with Director of Nurses (DON) on 7/24/2025 at 9:13 AM, DON stated it is embarrassing to have the damaged bed sheet for Resident 139. DON stated he will make sure CNAs use clean and good condition linen and bed sheets for all the residents. During a review of the facility's Policy and Procedure (P&P) titled, Homelike Environment reviewed in June/2024, indicated residents are provided with a safe, clean, comfortable and homelike environment and encouraged to use their personal belongings to the extent possible.Policy Interpretation and Implementation1. Staff provide person-centered care that emphasizes the residents' comfort, independence and personal needs and preferences.2. The facility staff and management maximize, to the extent possible, the characteristics of the facility that reflect a personalized, homelike setting include: clean bed and bath linens that are in good condition.

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review, the facility failed to ensure one (1) of five (5) sampled residents (Resident 1) was free from an unnecessary psychotropic drug (any medication capable of affecting the mind, emotions, and behavior) by failing to ensure Resident 1's Lorazepam (medication used to treat anxiety [persistent and excessive worry that interferes with daily activities) as needed (PRN) order had a documented rationale for extending the use beyond 14 days in accordance with the facility's policy. This deficient practice had the potential to place Resident 1 at risk for significant adverse consequences (serious negative outcomes resulting from an event, action, or situation) from the use of unnecessary psychotropic drug, which could result in impairment or decline in the residents' mental, physical condition, functional, and psychosocial statusDuring a review of Resident 1's admission Record, the admission Record indicated Resident 1 was initially admitted to the facility on [DATE] and readmitted on [DATE]. Resident 1's diagnoses included dementia (a progressive state of decline in mental abilities), depression (a mood disorder that can affect how you think, feel, and behave), and anxiety disorder (a natural human emotion characterized by feelings of worry, nervousness, or unease). During a review of Resident 1's Minimum Data Set (MDS - a resident assessment tool), dated 6/24/2025, the MDS indicated Resident 1's cognitive skills for daily decision making was severely impaired (never/rarely made decisions). The MDS indicated Resident 1 required supervision (helper provides verbal cues, resident completes activity) with eating. The MDS indicated Resident 1 required partial/moderate assistance (helper does less than half the effort) with oral hygiene and upper body dressing. The MDS indicated Resident 1 required substantial/maximal assistance (helper does more than half the effort) with toileting hygiene, shower, lower body dressing and putting on/off footwear. The MDS indicated Resident 1 was assessed to have mood symptoms. During a review of Resident 1's Physician's Order, dated 7/6/2025 the Physician's Order indicated Lorazepam as needed, give half (0.5) milligram (mg, unit of measurement) by mouth, every six (6) hours for anxiety manifested by repetitive verbal outburst for 30 days, with end date of 8/5/2025. During a review of Resident 1's Psychiatric Follow Up Note, dated 7/14/2025, the Psychiatric Follow Up Note indicated Due to continued usage of Ativan (Lorazepam), to be given to assist with management of behavior. Renewal every 30 days at this time. During a concurrent record review and interview on 7/24/2025 at 8:24 AM with Licensed Vocational Nurse 2 (LVN 2), Resident 1's lorazepam order and Individual Psychotherapy Progress Note, dated 7/7/2025 were reviewed. LVN 2 verified Resident 1 has an order of lorazepam as needed for anxiety ordered on 7/6/2025, for 30 days. LVN 2 stated the Physician Assistant (PA) ordered Resident 1's Lorazepam as needed on 7/6/2025. LVN 2 stated PA visited and had notes for Resident 1 on 7/7/2025 but did not indicate the reason why Resident 1 can be on as needed Lorazepam order for 30 days instead of limiting to 14 days. LVN 2 stated the PA should have limited Resident 1's Lorazepam order to 14 days and should have reevaluated to continue beyond 14 days and include the rationale per policy. During a telephone interview on 7/24/2025 at 9:16 AM with the Pharmacy Consultant (PC), the PC stated as needed Lorazepam order can be ordered for 30 days if there is a documentation from Psychiatrist (a medical practitioner specializing in the diagnosis and treatment of mental illness) as to why Lorazepam needs to be extended for more than 14 days. The PC stated that there was no Psychiatrist documentation prior to Resident 1's order of Lorazepam as needed order for 30 days on 7/6/2025. During an interview on 7/25/2025 at 12:07 PM with the Director of Nursing (DON), the DON stated as needed Lorazepam order should be limited to 14 days to minimize the use of psychotropic medication. The DON stated that when it comes to psychotropic orders, licensed nurses make sure the resident's physician or psychiatrist is aware of resident's status and behavior. The DON stated the psychiatrist needs to give the order for adjustments and duration. The DON added that when psychiatrist decides for as needed psychotropic medication to extend to 30 days, resident evaluation and rationale documentation should be done prior to putting an order. During a review of undated Facility's Policy and Procedure (P&P) titled, Psychotropic Medication Use, the P&P indicated PRN orders for psychotropic medications are limited to 14 days. If the prescriber or attending physician believes it is appropriate to extend the PRN order beyond 14 days, he or she will document the rationale for extending the use and include the duration for the PRN order.

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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** Based on observation, interview and record review, the facility failed to develop a care plan (a document that outlines the facility's plan to provide personalized care to a resident based on the resident's needs) for three (3) of 30 residents (Residents 8, 79, and 126) as follows:Resident 79's 1,000 cubic centimeters (cc- a measurement of volume) fluid restriction (limiting the amount of liquids a person consumes each day) as ordered by the physician. Regarding Resident 126's Intravenous (IV) antibiotic (medicines that fight bacterial infections) administration.Regarding Resident 8's use of bolster low air loss mattress.These failures had the potential for Residents 79, 126 and 8 to receive care that is not personalized to meet the specific needs identified above, which could result in decreased quality of care and quality of life. 1. During a review of Resident 79’s admission Record, the admission Record indicated Resident 79 was originally admitted to the facility on [DATE] with diagnoses that included end stage renal disease (ESRD- irreversible kidney failure), dependence on renal dialysis (a treatment to cleanse the blood of wastes and extra fluids artificially through a machine when the kidney[s] have failed) and heart failure (a chronic condition in which the heart does not provide adequate blood flow to meet the body’s needs). During a review of Resident 79’s “Minimum Data Set (MDS – a resident assessment tool),” dated 5/27/2025, the MDS indicated Resident 79 had intact cognitive skills (ability to understand and make decisions) for daily decision making. The MDS indicated Resident 79 required supervision or touching assistance (helper provides verbal cues, touching/steadying and/or contact guard assistance during activity) with eating, oral and personal hygiene and substantial/maximal assistance (helper does more than half the effort needed to complete the activity) toileting hygiene and bathing. The MDS also indicated Resident 79 received dialysis while a resident at the facility. During a review of Resident 79’s “Order Summary Report,” dated 7/9/2025, the Order Summary Report indicated an order for fluid restriction of 1,000cc per day: Nursing 280cc: 7-3 shift = 120cc, 3-11 shift = 100cc, 11-7 shift = 60cc Dietary 720cc: Breakfast =360cc, Lunch = 120cc, Dinner = 240cc Note: No water pitcher at bedside every shift. During a concurrent interview and record review on 7/23/2025 at 2:25 PM with Licensed Vocational Nurse 3 (LVN 3), Resident 79’s chart was reviewed. Resident 79’s chart failed to indicate a developed care plan indicating Resident 79’s 1,000cc fluid restriction. LVN 3 stated there should be a care plan indicating Resident 79’s fluid restriction but there was not. LVN 3 stated care plans focus on things related to the residents like fluid restriction and has a goal and interventions to meet the goal. LVN 3 also stated it was very important to ensure Resident 79’s fluid restriction of 1,000cc was developed and accurate to prevent complications with fluid overload and/or edema (swelling caused by excess fluid trapped in your body's tissues). (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 7/24/2025 at 9:57 AM with the Director of Nursing (DON), the DON stated Resident 79 did not and should have had a care plan developed for her 1,000cc fluid restriction. The DON indicated a care plan allows resident centered interventions to improve the quality of care provided to the residents, identifies if treatments are effective and if other treatments are needed to meet the goals of the resident. The DON also stated, without the care plan for Resident 79’s 1,000cc fluid restriction, the staff will not have the right information to provide the right care. 2. During a review of Resident 126’s admission Record, the admission Record indicated the facility initially admitted Resident 126 on 12/5/2023 and was readmitted on [DATE] with diagnoses that included, but not limited to, cellulitis (skin infection that affects the deeper layers of the skin [dermis] and the tissues beneath)of the abdominal wall (layered structure of muscles, fascia, and other tissues that surrounds and protects the organs within the abdomen), long term use of antibiotics, deep incisional surgical (a cut or wound made with a sharp object, particularly in surgery to create and opening in the body) infection, and diabetes mellitus (disease where body has trouble regulating blood sugar levels). During a review of Resident 126’s MDS, dated [DATE], the MDS indicated Resident 126 had moderate cognitive impairment for daily decision making. The MDS also indicated Resident 126 required supervision or touching assistance with eating. The MDS indicated Resident 126 required partial/moderate assistance (Helper does less than half the effort. Helper lifts, holds, or supports trunk or limbs, but provides less than half the effort) with oral and personal hygiene. The MDS indicated Resident 126 required substantial/maximal assistance (Helper does more than half the effort. Helper lifts or holds truck or limbs and provides more than half the effort) with upper body dressing and was dependent (Helper does all the effort. Resident does none of the effort to complete the activity. Or the assistance of 2 or more helpers is required for the resident to complete the activity) with toileting hygiene, shower/bathing self, lower body dressing and putting on/taking off footwear. During an observation on 7/21/2025 at 11:08 AM, in Resident 126’s room, Resident 126 was awake and lying flat in bed. Resident 126 was also observed with intravenous (administered into a vein) peripheral (superficial) access on his right hand. During a review of Resident 126’s Order for IV Orders, the IV Orders indicated: 1 Ceftriaxone Sodium Injection Solution Reconstituted two gram (gm-unit of weight in the metric system, equal to one-thousandth of a kilogram) IV. Use two gm IV one time a day for surgical wound infection for four weeks ordered on 7/19/2025. 2 Vancomycin (Pharmacy to dose) ordered on 7/19/2025. 3 Vancomycin IV 750 milligram (mg-a unit of mass equal to one-thousandth of a gram) in 150 milliliters (ml-unit of volume used to measure liquids). Use 750 mg IV one time a day for surgical wound infection for four weeks, ordered on 7/19/2025 for four weeks. During a concurrent interview and record review on 7/23/2025 at 4:47 PM with the, the MAR for July 2025 was reviewed. The MAR indicated Resident 126 had been administered Vancomycin IV Solution 750 mg in 150 ml, use 750 mg IV, one time a day for surgical wound infection for four weeks starting 7/19/2025 and Ceftriaxone two gm, one time a day for surgical wound infection starting 7/19/2025 until 8/14/20. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 7/24/2025 at 7:45 AM with the DON, the DON stated that there was no care plan (a document that outlines the individualized care a patient will receive, detailing their specific needs, goals, and interventions) initiated for IV antibiotic administration for Resident 126. The DON stated that all licensed nurses can initiate care plans and the licensed nurse that received the IV antibiotic order should have initiated a care plan on 7/19/2025. During a concurrent interview and record review on 7/24/2025 at 10:46 AM with the Minimum Data Set Nurse (MDSN), the baseline care plan was reviewed for Resident 126. The baseline care plan indicated the administration of IV medications-antibiotics; however, no patient centered care plan was initiated to address IV Vancomycin administration. The MDSN stated that care plans were important so that every staff member was aware of Resident 126’s problems, goals and interventions. The MDSN stated that the care plan was a way of communicating to the rest of the Interdisciplinary team (IDT) how care should be for the residents. 3. During a review of Resident 8’s admission Record, the admission Record indicated the resident was originally admitted to the facility on [DATE], and readmitted on [DATE], with diagnosis of pressure ulcer of sacral region (wounds that form as a direct result of pressure over a bony prominence), abnormal posture, and muscle weakness. During a review of Resident 8’s MDS, dated [DATE], indicated Resident 8's cognitive skills for daily decision making was moderately impaired (some difficulty in situations only). The MDS indicated Resident 8 required substantial/maximal assistance (helper does more than half the effort) with eating and oral hygiene. The MDS indicated Resident 8 was dependent (helper does all the effort) with toileting hygiene, shower, upper body dressing, lower body dressing and putting on/taking off footwear. During a review of Resident 8’s Braden scale for predicting pressure sore risk (a tool used in healthcare to assess a resident’s risk of developing pressure ulcers by evaluating six factors: sensory perception, moisture, activity, mobility, nutrition, and friction/shear), dated 6/16/2025, indicated Resident 8 was at moderate risk for pressure sores due total score of 13. During an observation on 7/21/2025 at 2 PM, Resident 8 was observed in bed, lying on a bolster low air loss mattress. During a concurrent observation on 7/22/2025 at 2:43 PM, and interview with Certified Nurse Assistant 6 (CNA 6), Resident 8 was observed lying in bed with bolster low air loss mattress. CNA 6 stated Resident 8 has that kind of mattress for a while now. CNA 6 stated Resident 8 needs it to prevent him from sliding and falling out of bed. During a concurrent record review on 7/23/2025 at 9:51 AM, and interview with Licensed Vocational Nurse 6 (LVN 6), Resident 8’s care plan were reviewed. LVN 6 stated Resident 8 did not and should have had a care plan regarding the use of bolster low air loss mattress. LVN 6 stated Resident 8’s care plan is to use low air loss mattress for skin maintenance/wound maintenance, that was created on 5/27/2025. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 7/24/2025 at 11:57 AM with the DON, the DON verified Resident 8 did not have a care plan for the use of bolster LALM. The DON stated bolster LALM should have a care plan that included monitoring of bolster’s placement because they are removable, and staff should make sure that it is on the side and not in the middle of the mattress where it might cause more skin issues to Resident 8. The DON also added that the bolster low air loss mattress might limit Resident 8’s access to the bed rails, and staff should know how to check proper placement for Resident 8’s safety. During a review of the facility’s policy and procedure (P&P) titled “Care Plan- Comprehensive Person- Centered,” dated 1/2025, the P&P indicated an individualized comprehensive care plan that includes measurable objectives and timetables to meet the resident’s medical, nursing, mental and psychological needs is developed for each resident within seven (7) days of the completion of the resident’s comprehensive assessment, and revised as changes in the resident’s condition dictates. The P&P also indicated each resident’s comprehensive care plan has been designed to: Incorporate identified problem areas; Incorporate risk factors associated with identified problems; Build on the resident’s strengths; Reflect treatment goals and objectives in measurable outcomes; Identify the professional services that are responsible for each element of care; Aid in preventing or reducing declines in the resident’s functional status and/or functional levels; and Enhance the optimal functioning of the resident by focusing on a rehabilitative program.

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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** Based on observation, interview, and record review, the facility failed to ensure the bolster (a raised, often inflatable, perimeter around the edges of the mattress that helps prevent patients from rolling out) low air loss mattress (LALM- a specialized medical mattress designed to prevent and treat pressure ulcer [pressure injury- wound that occurs as a result of prolonged pressure on a specific area of the body] by maintaining a cool, dry environment through constant airflow, which helps regulate temperature and moisture) was ordered for one (1) of five (5) sampled residents (Resident 8). This deficient practice had the potential for Resident 8's pressure ulcer to worsen and for the resident to develop new pressure injury.During a review of Resident 8's admission Record, the admission Record indicated the resident was originally admitted to the facility on [DATE], and readmitted on [DATE], with diagnosis of pressure ulcer of sacral region (are wounds that form as a direct result of pressure over a bony prominence), abnormal posture and muscle weakness. During a review of Resident 8's Minimum Data Set (MDS- a resident assessment tool), dated 5/29/2025, indicated Resident 8's cognitive (ability to think and reason) skills for daily decision making is moderately impaired (some difficulty in situations only). The MDS indicated Resident 8 required substantial/maximal assistance (helper does more than half the effort) with eating and oral hygiene. The MDS indicated Resident 8 was dependent (helper does all the effort) with toileting hygiene, shower, upper body dressing, lower body dressing and putting on/taking off footwear. During a review of Resident 8's Braden scale for predicting pressure sore risk (a tool used in healthcare to assess a resident's risk of developing pressure ulcers by evaluating six factors: sensory perception, moisture, activity, mobility, nutrition, and friction/shear), dated 6/16/2025, indicated Resident 8 was at moderate risk for pressure sores due total score of 13. During an observation on 7/21/2025 at 2 PM, Resident 8 was observed in bed, lying on a bolster low air loss mattress. During a concurrent observation, and interview with Certified Nurse Assistant 6 (CNA 6), Resident 8 was observed lying in bed with bolster low air loss mattress. CNA 6 stated Resident 8 has that kind of mattress for a while now. CNA 6 stated Resident 8 needs it to prevent him from sliding and falling out of bed. During a concurrent record review on 7/23/2025 at 9:50 AM, and interview with Licensed Vocational Nurse 6 (LVN 6), Resident 8's active orders as of 7/23/2025 were reviewed. The order did not indicate for Resident 1 to have a bolster low air loss mattress. LVN 6 stated Resident 8 has bolster low air loss mattress but without a physician's order. LVN 6 verified Resident 8 have an order to monitor placement, setting and functioning of low air loss mattress, ordered on 5/27/2025. LVN 6 stated bolster low air loss mattress is different from just low air loss mattress, and it should have been in Resident 8's physician order instead. During an interview on 7/23/2025 at 10:48 AM with the Director of Nursing (DON), the DON confirmed, after the Interdisciplinary Team (IDT, refers to a group of healthcare professionals from different disciplines who collaborate to provide comprehensive care for a resident) discussion regarding Resident 8's need of low air loss mattress, it was decided that bolster low air loss mattress will be more beneficial for Resident 8 to prevent him from falling out of bed. The DON admitted that the order for bolster low air loss mattress was not in Resident 8's physician's order. During an interview on 7/24/2025 at 11:56 AM with the DON, the DON is unable to provide Policy and Procedures (P&P) regarding bolster low air loss mattress. The DON added bolster low air loss mattress should be in Facility's P&P since Resident 8 is using it. During a review of Facility's undated P&P, titled Air Mattress, the purpose indicated the following: To decrease pressure from the resident's weight in bed. To promote the healing of or the prevention of pressure ulcers.

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility did not ensure one of three sampled residents (Resident 87), received the correct amount of water flush via gastrostomy tube (GTube- a surgical opening fitted with a device to allow feedings to be administered directly to the stomach common for people with swallowing problems) after medication administration as indicated in the physician's order and care plan (a document that outlines the facility's plan to provide personalized care to a resident based on the resident's needs).This failure resulted in a decreased amount of water administration for Resident 87, with the potential risk for Resident 87 to experience inadequate hydration and/or clogging of the GTube, causing decreased nutrition and hydration.Findings:During a review of Resident 87's admission Record, the admission Record indicated Resident 87 was admitted to the facility on [DATE], with diagnoses that included gastrostomy status, moderate protein-calorie malnutrition (a nutritional deficiency where the body doesn't receive enough protein and calories to meet its needs), and aphasia (a disorder that makes it difficult to speak). During a review of Resident 87's Medication Administration Record (MAR), dated 5/26/2025, the MAR indicated an enteral (the administration of substances directly into the gastrointestinal [GI] tract, through a tube) feed order every shift flush tube with 30 to 50 cubic centimeters (cc-a measurement of volume) of fluid before and after medication administration. During a review of Resident 87's Minimum Data Set (MDS - a resident assessment tool), dated 6/6/2025, the MDS indicated resident 87 with severely impaired cognitive skills (ability to understand and make decisions) for daily decision making. The MDS indicated Resident 87 was dependent (helper does all effort needed to complete activity) with oral, toileting and personal hygiene, showering/bathing and dressing. The MDS also indicated Resident 87 had a feeding tube (a small, flexible tube that provides liquid nutrition, fluids and medication to people who are unable to eat or swallow normally), receiving 51% or more calories and 501 cc or more per day, through the feeding tube. During a review of Resident 87's care plan titled Dependent on Tube Feeding for All Nutrition and Hydration, dated 6/8/2025, the care plan indicated intervention to include for staff to flush tube with 50 cc of water pre (before) and post (after) medication administration via tube and to flush tube as ordered. The care plan also indicated a goal for Resident 87 to be adequately nourished and hydrated. During a concurrent observation in Resident 87's bedside and interview on 7/22/2025 from 8:51 AM to 8:59 AM with Licensed Vocational Nurse 3 (LVN 3), LVN 3 was observed flushing Resident 87's GTube with 5 cc of water after administration of the following medications:a. Gabapentin (medication used to manage certain types of epileptic seizures [sudden surges of abnormal electrical activity in the brain that can cause loss of consciousness, muscle spasm, and changes in sensation, mood, or behavior] and to relieve nerve pain) 100 milligrams (mg- a unit of mass or weight).b. Lisinopril (medication to lower blood pressure) 2.5 mg.c. Levetiracetam (medication used to treat and prevent seizures) 500 mg/ 5 milliliters (ml - a measurement of volume).d. Aspirin (medication that works by making the blood less sticky) 81 mg.LVN 3 stated he flushed 5 cc of water after the administration of Resident 87's medications. During a concurrent interview and record review on 7/22/2025 at 9:06 AM with LVN 3, Resident 87's Order Summary Report, dated 5/26/2025 was reviewed. The Order Summary Report indicated an enteral (the administration of substances directly into the gastrointestinal [GI] tract, through a tube) feed order every shift flush tube with 30-50 cc of fluid before and after medication administration. LVN 3 stated he should have used 30 to 50 cc of water to flush after giving medications and he did not. LVN 3 stated it was important to follow the physician's order and give the right amount of water flush to prevent the GTube from clogging and to ensure the medications were administered and absorbed. During an interview on 7/24/2025 at 9:49 AM with the Director of Nursing (DON), the DON stated water flushes are to be given as ordered. During a review of the facility's Policy & Procedure (P&P) titled, Enteral Nutrition, dated 1/2025, the P&P indicated adequate nutritional support through enteral nutrition is provided to residents as ordered.

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide for the safe, appropriate administration of IV fluids for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to follow its Policy and Procedure (P&P) on intravenous (into the through the vein) therapy for two (2) of three (3) sampled residents (Residents 54 and 58) by failing to ensure: 1. Resident 54's IV tubing (a flexible plastic tube that delivers fluids, medications, and other therapies into the body through a vein) was labeled. This deficient practice had the potential to put Resident 54 at risk of getting a bloodborne (carried by the blood) infection. 2. Resident 58's IV site was monitored every shift as indicated in the resident IV antibiotic (ATB, [medicines that fight bacterial infections]) care plan. This failure had the potential to put Resident 58 at risk for developing an infection and complications.Based on observation, interview and record review, the facility failed to follow its Policy and Procedure (P&P) on intravenous (into the body through the vein) therapy for two (2) of three (3) sampled residents (Residents 54 and 58) by failing to ensure: 1. Resident 54’s IV tubing (a flexible plastic tube that delivers fluids, medications, and other therapies into the body through a vein) was labeled. This deficient practice had the potential to put Resident 54 at risk of getting a bloodborne (carried by the blood) infection. Findings: 1. During a review of Resident 54’s admission Record, the admission Record indicated the resident was admitted to the facility on [DATE] with diagnoses that included type 2 diabetes (a disease in which your body does not produce enough insulin needed to control sugar levels in the blood), and osteomyelitis (bone infection). During a review of Resident 54’s Minimum Data Set (MDS, a care assessment and screening tool) dated 5/28/2025, the MDS indicated the resident was assessed to have intact cognitive (capable of remembering, learning new things, concentrating, or making decisions that affect everyday life) skills for daily decision making. Resident 54 required substantial/maximal assistance (helper does more than half the effort) for toileting hygiene, showering, lower body dressing and putting on/taking off footwear. The MDS also indicated Resident 54 required partial/moderate assistance (helper does less than half the effort) for upper body dressing. The MDS also indicated Resident 54 required supervision (helper provides verbal cues) for eating, and oral hygiene. During a review of Resident 54’s Order Summary Report (OSR) dated 7/19/2025, the OSR indicated Resident 54 was ordered Ceftriaxone (an antibiotic to treat infection) intravenously (to be administered into the body through a vein). During an observation in Resident 54’s room on 7/21/2025 at 9:08 AM, Resident 54’s IV tubing was observed, and it was unlabeled. During a concurrent interview and observation on 7/21/2025 at 9:15 AM with licensed vocational nurse 1 (LVN 1), LVN 1 stated Resident 54’s IV tubing was unlabeled. LVN 1 stated Resident 54’s IV tubing should have been labeled. LVN 1 stated that if IV tubing is not labeled, staff will not know how old the tubing is, and it may be gathering bacteria which may get a resident sick. (continued on next page)

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review on 7/24/2025 at 8:10 AM with the Director of Nursing (DON) the facility’s policy and procedure (P&P) titled, Administration Set/Tubing Changes (ASTC) (undated) and the P&P titled Infection Prevention and Control Program (IPCP), dated 1/6/2025 were reviewed. The IPCP P&P indicated: An IPCP is established and maintained to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. Prevention of infection includes identifying possible infections or potential complications. The ASTC P&P indicated: The purpose of this procedure is to provide guidelines for aseptic administration set changes in order to prevent infections associated with contaminated IV therapy equipment. Label administration set and tubing with date, time and initials. The DON stated that IV tubing must be labeled with a time and date for infection control purposes so that staff may know how old a tubing is and change it if necessary. The DON stated that old tubing accumulates bacteria which may cause a resident to get a bloodborne infection. The DON stated that not labeling IV tubing violates the IPCP and ASTC policies. 2. During a review of Resident 58’s admission Record, the admission Record indicated the resident was originally admitted to the facility on [DATE], readmitted on [DATE] with diagnosis of extended-spectrum beta-lactamase (ESBL -bacteria that’s resistant to many commonly used antibiotics) resistance, klebsiella (a type of bacteria, commonly found in the human gut and sometimes causing infections) and Alzheimer’s Disease (a disease characterized by a progressive decline in mental abilities). During a review of Resident 58’s MDS, dated [DATE], the MDS indicated Resident 58's cognitive skills for daily decision making were moderately impaired (decisions poor; cues/supervision required). The MDS indicated Resident 58 required partial/moderate assistance (helper does less than half the effort) with eating. The MDS indicated Resident 58 was dependent (helper does all the effort) with oral hygiene, toileting hygiene, shower, upper body dressing, lower body dressing, and putting off footwear. During a review of Resident 58’s care plan that focuses on Resident 58 requires IV therapy for ESBL urine and potential for infection and or complications related to IV access (IV site, the specific location on the body where a needle or catheter is inserted into a vein to deliver fluids, medications) and medication administration, the care plan indicated the following staff interventions: · Flush IV line as ordered, initiated on 7/15/2025. · Observe IV line for any signs and symptoms of complications such as swelling, redness, leakage, and drainage. Initiated on 7/15/2025. (continued on next page)

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 58’s Physician Orders, the Physician Orders indicated an order of Ertapenem (IV antibiotic used to treat various serious bacterial infections by killing or preventing bacterial growth) solution, use 500 milligrams (mg, unit of measurement) every 24 hours for ESBL urine until 7/22/2025. During a review of Resident 58’s IV Therapy Medication Record, the IV Therapy Medication Record indicated site check every shift for complications and no adverse reactions from IV therapies unless addressed in nurses’ notes. There were no Registered Nurse (RN) initials to reflect that the IV site for Resident 58 was assessed for the Night (NOC, 11PM to 7AM) shift on 7/14/2025, 7/15/2025, 7/16/2025, 7/17/2025, 7/18/2025, 7/19/2025, 7/20/2025, 7/21/2025, 7/22/2025. During a concurrent observation and interview on 7/21/2025 at 1:56 PM, Resident 58 stated she stopped getting IV medication but does not remember when. Resident 58 stated she does not have an IV line anymore. During an interview on 7/22/2025 at 3:45 PM with RN 2, RN 2 stated she did not check and flush Resident 58’s IV line during her shift which was 7 AM to 3:30 PM on 7/22/2025. During a concurrent record review and interview with MDS nurse (MDSN), Resident 58’s medical records were reviewed. The MDSN stated Resident 58’s care plan for IV therapy was partially implemented. The MDSN verified that Resident 58’s intravenous therapy medication record has incomplete documentation from NOC RNs. MDSN verified that none of the NOC RNs documented in nurses’ notes regarding their assessment and condition of Resident 58’s IV site. MDSN stated if it was not documented, it was not done. MDSN added it was important to check IV site to ensure its patency, for safety and effective IV treatment. During an interview on 7/23/2025 at 8:38 AM with RN 1, RN 1 stated it was important to maintain an IV site for the residents with ongoing IV therapy. RN 1 stated it was important that there was continuous assessment of resident’s IV site until IV therapy is discontinued to ensure that resident have an IV access to receive the IV antibiotic. RN 1 added this will also ensure that the IV site is in place, and there is no IV infiltration (occurs when IV fluids or medications leak out of the vein and into the surrounding tissue). During a review of facility’s P&P titled, “Continuous Infusion of Medications and Solutions, ” dated March 2023, indicated the following: · The nurse will monitor the venous access site frequently for signs and symptoms of complications. · Condition of the venous access site will be documented at least every shift with consideration given to prescribed therapy and the condition of the residents.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to monitor the daily fluid restrictions (limiting the amount of liquids a person consumes each day) of 1000 cubic centimeters (cc- a measurement of volume) for one of five residents (Resident 79) on dialysis (a treatment to cleanse the blood of wastes and extra fluids artificially through a machine when the kidney[s] have failed) as ordered by the physician. This failure had the potential for Resident 79 to experience complications including fluid overload (having too much fluid in the body) which could negatively affect the resident's overall wellbeing.Findings:During a review of Resident 79's admission Record, the admission Record indicated Resident 79 was originally admitted to the facility on [DATE] with diagnoses that included End Stage Renal Disease (ESRD- irreversible kidney failure), dependence on renal dialysis, and heart failure (a chronic condition in which the heart does not provide adequate blood flow to meet the body's needs). During a review of Resident 79's Minimum Data Set (MDS - a resident assessment tool) dated 5/27/2025, the MDS indicated Resident 79 had intact cognitive skills (ability to understand and make decisions) for daily decision making. The MDS indicated Resident 79 was supervision or touching assistance (helper provides verbal cues, touching/steadying and/or contact guard assistance during activity) with eating, oral and personal hygiene and substantial/maximal assistance (helper does more than half the effort needed to complete the activity) toileting hygiene and bathing. The MDS also indicated Resident 79 received dialysis while a resident at the facility. During a review of Resident 79's Order Summary Report, dated 7/9/2025, the Order Summary Report indicated an order for fluid restriction of 1000cc per day: Nursing 280cc: 7 to 3 shift = 120cc, 3 to 11 shift = 100cc, 11 to 7 shift = 60ccDietary 720cc: Breakfast =360cc, Lunch = 120cc, Dinner = 240ccNote: No water pitcher at bedside every shift. During a concurrent interview and record review on 7/23/2025 at 2:05 PM with Licensed Vocational Nurse 8 (LVN 8), Resident 79's Medication Administration Record (MAR) dated 7/9/2025 to 7/31/2025 was reviewed. The MAR indicated fluid restriction of 1000cc/day: Nursing 280cc: 7 to 3 shift = 120cc, 3 to 11 shift = 100cc, 11 to 7 shift = 60ccDietary 720cc: Breakfast =360cc, Lunch = 120cc, Dinner = 240ccNote: No water pitcher at bedside every shift.The MAR failed to indicate a recorded amount of daily fluid intake amounts for each shift (day, evening and night) from 7/9/2025 to 7/23/2025. LVN 8 stated there was no documentation of Resident 79's daily intakes each shift, but there should be. LVN 8 stated Resident 79's fluid restriction order was entered incorrectly onto the MAR allowing nursing to only acknowledge the fluid restriction order, but not document actual intake amounts for Resident 79. During an interview on 7/23/2025 at 2:18 PM with LVN 7, LVN 7 stated daily fluid restriction monitoring is done by documenting the amount of fluids consumed by the resident each shift on the MAR. LVN 7 also stated there is no other location for the fluid intakes to be documented by the licensed nursing staff. During a concurrent interview and record review on 7/23/2025 at 2:25 PM with LVN 3, Resident 79's chart was reviewed. Resident 79's chart failed to indicate fluid intake amounts by licensed nursing staff from 7/9/2025 to 7/23/2025. LVN 3 stated licensed nursing staff did not document any notes to indicate intake amounts for Resident 79 for any shift from 7/9/2025 to 7/23/2025 and should have. LVN 3 stated without accurate, and complete recorded daily intake amounts for each shift, there is no way to ensure Resident 79's fluid intake is being monitored, and fluids are given within the ordered fluid restriction. LVN 3 stated Resident 79 is at a high risk for accumulating fluids so accurate and complete fluid intake monitoring is necessary to prevent guessing and ensure actual intake amounts are monitored and reported to dialysis and medical staff. During an interview on 7/24/2025 at 9:52 AM with the Director of Nursing (DON), the DON stated Resident 79 should have her fluid intake monitored according to policy and physician's order and documented to prevent edema (swelling caused by excess fluid trapped in your body's tissues), shortness of breath and/or fluid overload. During a review of the facility's policy and procedure (P&P) titled, Care of the Dialysis Resident, dated 2019, the P&P indicated special care monitoring for residents on dialysis including fluid restriction, diet and medications as ordered. The P&P also indicated the policy purpose to prevent complications such as fluid overload, infection or clotting of the access area, or hemorrhage in the dialysis resident.

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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 0732 Level of Harm - Potential for minimal harm Residents Affected - Some	Post nurse staffing information every day. Based on observation, interview and record review, the facility failed to ensure accurate and up to date staffing information was posted and placed in a visible and prominent place on 7/19/2025 to 7/21/2025. As a result, the total number of staff and the actual hours worked by the staff were not readily accessible to residents and visitors. During an observation on 7/21/2025 at 7:33 AM, the daily staffing information dated 7/18/2025 was observed at the front reception desk near the facility's front entrance area. There was no other updated staff posting found. During an observation on 7/21/2025 at 10:48 AM, the daily staffing information dated 7/18/2025 was still posted at the reception area without any up-to-date staffing information for 7/21/2025. During an interview on 7/24/2024 at 8:43 AM with Director of Staff Development (DSD), DSD stated he is the one in charge of the staffing hours posting of the projection and actual hours of staffing. DSD stated he needs to do the staff posting every day and post it every morning at the designated area (reception area at the lobby of the facility). DSD stated the weekend registered nurse supervisor (RNS) was supposed to post the weekend staffing hours at the designated area for 7/19/2025 and 7/20/2025. DSD stated he was supposed to post the weekday staffing hours for 7/21/2025 first thing in the morning so that sufficient numbers of nursing staff with the appropriate skills and competency necessary to provide care and services can be up to date. During an interview on 7/24/2024 at 11:13 AM with RNS, RNS stated she only works part-time at the facility and does not usually take care of the staffing posting. RNS stated she did not know that she was assigned to post daily staffing hours during the weekend. RNS stated staffing information keeps staff updated and ensures that the facility has enough staff for that day to provide care and services to the residents. During an interview on 7/24/2024 at 11:16 AM with the Director of Nursing (DON), the DON stated it is very important to post the daily staffing hours to make sure the facility has enough nurses to provide care and services for all residents. During a review of the facility's Policy and Procedure (P&P) titled, Staffing, Sufficient and Competent Nursing, reviewed in January 2025, the P&P indicated the facility provides sufficient numbers of nursing staff with the appropriate skills and competency necessary to provide nursing and related care and services for all residents in accordance with resident care plans and the facility assessment. Staffing numbers and the skill requirements of direct care staff are determined by the needs of the residents based on each resident's plan of care, the resident assessments and the facility assessment. Direct care daily staffing numbers (the number of nursing personnel responsible for providing direct care to residents) are posted in the facility for every shift.

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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. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide a consistent and accurate account for controlled medications (medications that the use and possession of are controlled by the federal government) through staff documentation for all the controlled medication at shift change. This has the potential for the facility staff to not secure and safeguard controlled medications and not be able to account that the medications were administered to the residents safely and accurately.Findings:During a review of Resident 87's admission Record, the admission Record indicated Resident 87 was admitted to the facility on [DATE], with diagnoses that included gastrostomy status (GTube- a surgical opening fitted with a device to allow feedings to be administered directly to the stomach common for people with swallowing problems), moderate protein-calorie malnutrition (a nutritional deficiency where the body doesn't receive enough protein and calories to meet its needs), and aphasia (a disorder that makes it difficult to speak). During a record review of Resident 87's Order Summary Report dated 5/26/2025, the Order Summary Report indicated an enteral (the administration of substances directly into the gastrointestinal [GI] tract, through a tube) feed order every shift flush tube with 10-15 (cc-a measurement of volume) of water in between each medication administered and flush tube with 30-50cc of fluid before and after medication administration. During a review of Resident 87's Minimum Data Set (MDS - a resident assessment tool), dated 6/6/2025, the MDS indicated resident 87 with severely impaired cognitive skills (ability to understand and make decisions) for daily decision making. The MDS indicated Resident 87 was dependent (helper does all effort needed to complete activity) with oral, toileting and personal hygiene, showering/bathing and dressing. The MDS also indicated Resident 87 had a feeding tube (a small, flexible tube that provides liquid nutrition, fluids and medication to people who are unable to eat or swallow normally), receiving 51% or more calories and 501 cc or more per day, through the feeding tube. During an interview on 7/22/2025 at 2:33 PM (I/LRR) with Licensed Vocational Nurse 7 (LVN 7), LVN 7 stated the Narcotic (a drug or other substance that affects mood or behavior) Release Forms document the completed narcotic count checks between incoming and outgoing nurses. During a concurrent interview and record review on 7/22/2025 at 2:41 PM with LVN 10, the Narcotic Release Form dated 7/2025, for Medication Cart C was reviewed. The Narcotic Release Form indicated blank entries on 7/1/2025, 7/4/2025, 7/6/2025, 7/7/2025, 7/8/2025, 7/13/2025, and 7/18/2025. LVN 10 stated there were missing entries and the Narcotic Release Form should have been filled out completely. LVN 10 stated per facility protocol, licensed nurses are to count and check the narcotics with the incoming and outgoing nurses and then complete the form every shift. LVN 10 stated there was no reason for the Narcotic Release Form to be left incomplete if staff document at the time of the count and without documentation, there is no way to ensure it was done. During a concurrent interview and record review on 7/23/2025 at 9:03 AM with the Director of Nursing, the Narcotic Release Forms, dated 7/2025, for Medication Carts A, B, D and E were reviewed. The DON verified that the Narcotic Release Forms indicated the following:A. Medication Cart A had blank entries (no signatures) between varied shifts on 7/2/2025, 7/3/2025, 7/4/2025, 7/6/2025 to 7/19/2025.B. Medication Cart B had blank entries between varied shifts on 7/15/2025 and 7/17/2025.C. Medication Cart D had blank entries between varied shifts on 7/1/2025, 7/6/2025, 7/7/2025, 7/9/2025, 7/11/2025 and 7/21/2025.D. Medication Cart E had blank entries between varied shifts on 7/6/2025, 7/8/2025, 7/10/2025, 7/11/2025, 7/12/2025, 7/13/2025, 7/20/2025 - 7/22/2025. The DON stated the Narcotic Release Forms were incomplete and should have been filled out completely per facility policy. The DON stated because the Narcotic Release Forms were incomplete, there was no way to ensure they were accurate. The DON stated incomplete and inaccurate forms may indicate licensed nurses were not being compliant with narcotic count and could create a discrepancy (difference) in the amount of narcotics actually available for the residents and delay treatments, which could negatively affect residents' quality of care received. During a review of the facility's Policy and Procedure (P&P) titled, Medication Storage in the Facility, dated 8/2014, the P&P indicated at each shift change, a physical inventory of all controlled medications, including the emergency supply is conducted by two licensed nurses and is documented on the controlled medication accountability record.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure its medication error rate was less than five (5) percent (%). Three (3) medication errors (the observed or identified preparation or administration of medications or biologicals which is not in accordance with the prescriber's order/ manufacturer's specifications / accepted professional standards and principles) out of 25 opportunities (observed administered medications) for error, which yielded a facility medication rate of 12.5% for one (1) of four (4) sampled residents (Resident 87). Licensed Vocational Nurse 3 (LVN 3) failed to administer 10 to 15 cubic centimeters (cc-unit of volume) of water (fluid) via Resident 87's gastrostomy tube (GTube- a surgical opening fitted with a device to allow feedings to be administered directly to the stomach common for people with swallowing problems) in between each medication in accordance with the physician's order.This failure resulted in Resident 87 not receiving the prescribed amount of water to meet the resident's individual medication needs.Findings:During a review of Resident 87's admission Record, the admission Record indicated Resident 87 was admitted to the facility on [DATE], with diagnoses that included gastrostomy status, moderate protein-calorie malnutrition (a nutritional deficiency where the body doesn't receive enough protein and calories to meet its needs), and aphasia (a disorder that makes it difficult to speak).During a review of Resident 87's Minimum Data Set (MDS - a resident assessment tool), dated 6/6/2025, the MDS indicated resident 87 with severely impaired cognitive skills (ability to understand and make decisions) for daily decision making. The MDS indicated Resident 87 was dependent (helper does all effort needed to complete activity) with oral, toileting and personal hygiene, showering/bathing and dressing. The MDS also indicated Resident 87 had a feeding tube (a small, flexible tube that provides liquid nutrition, fluids and medication to people who are unable to eat or swallow normally), receiving 51% or more calories and 501 cubic centimeters or more per day, through the feeding tube.During a review of Resident 87's Medication Administration Record (MAR), dated 5/26/2025, the MAR indicated an enteral (the administration of substances directly into the gastrointestinal [GI] tract, through a tube) feed order every shift to flush Gtube with 10-15 cc of water in between each medication administered.During a review of Resident 87's Care Plan (a document that outlines the facility's plan to provide personalized care to a resident based on the resident's needs) titled, Dependent on Tube Feeding for All Nutrition and Hydration, dated 6/8/2025, the Care Plan indicated for staff to flush tube with 15 cc of water in between each medication and to flush tube as ordered. During a concurrent observation at Resident 87's bedside and interview on 7/22/2025 from 8:51 AM to 8:59 AM with Licensed Vocational Nurse 3 (LVN 3), LVN 3 was observed flushing Resident 87's GTube with 5 cc of water in between the following medications:a. Gabapentin (medication used to manage certain types of epileptic seizures [sudden surges of abnormal electrical activity in the brain that can cause loss of consciousness, muscle spasm, and changes in sensation, mood, or behavior] and to relieve nerve pain) 100 milligrams (mg- a unit of mass or weight).b. Lisinopril (medication to lower blood pressure) 2.5 mg.c. Levetiracetam (medication used to treat and prevent seizures) 500 mg/ 5 milliliters (ml - a measurement of volume).d. Aspirin (medication that works by making the blood less sticky) 81 mg.LVN 3 stated he flushed 5 cc of water between each of Resident 87's medications during medication administration.During a concurrent interview and record review on 7/22/2025 at 9:06 AM with LVN 3, Resident 87's Order Summary Report, dated 5/26/2025 was reviewed. The Order Summary Report indicated an enteral feed order every shift to flush tube with 10 to 15 cc of water in between each medication administered. LVN 3 stated he should have used 10 to 15 cc of water to flush between each medication, and because he did not, he made medication errors. LVN 3 stated it was important to follow the physician's order and give the right amount of water flush to prevent the GTube from clogging and to ensure the medication was administered and absorbed.During an interview on 7/24/2025 at 9:49 AM with the Director of Nursing (DON), the DON stated medications, including water flushes, were to be given as ordered. The DON stated it was important for staff to give the correct amount of water flush between each medication to ensure the medication was entirely administered. During a review of the facility's policy & procedure (P&P) titled Administering Medications, dated 7/2024, the P&P indicated medications will be administered in a safe and timely manner, and as prescribed and medications must be administered in accordance with the orders.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility did not ensure the glucose test strips (small, plastic strips used with a glucose meter to measure the amount of glucose [sugar] in a blood sample) were not expired prior to blood sugar testing for one of two sampled residents (Resident 6) observed during medication administration. This deficient practice had the potential to cause inaccurate test results in the testing of Resident 6's blood sugar, leading to inappropriate and ineffective treatment and management. Findings:During a review of Resident 6's admission Record, the admission Record indicated Resident 6 was admitted to the facility on [DATE] with diagnoses that included type 2 diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing), peripheral vascular disease (PVD - a slow progressive narrowing of the blood flow to the arms and legs) and gastrostomy (a surgical opening fitted with a device to allow feedings to be administered directly to the stomach common for people with swallowing problems). During a review of Resident 6's Minimum Data Set (MDS - a resident assessment tool), dated [DATE], the MDS indicated Resident 6 had severely impaired cognitive skills (ability to understand and make decisions) for daily decision making. The MDS also indicated Resident 6 was dependent (helper does all effort needed to complete activity) with oral, personal and toileting hygiene, eating, bathing and dressing. The MDS also indicated Resident 6 received insulin (a hormone that removes excess sugar from the blood, can be produced by the body or given artificially via medication). During a review of Resident 6's Medication Administration Record (MAR), dated [DATE], the MAR indicated for regular insulin (a hormone that removes excess sugar from the blood, can be produced by the body or given artificially via medication) injection as per sliding scale: if 140 to 180 = 1 unit (a measurement of a substance), 181 to 240 = 2 units, 241-300 = 3 units, 301 to 350 = 4 units, 351 to 400 = 5 units 401+ = 6 units subcutaneously (area beneath the skin, in fatty tissue) before meals and at bedtime for DM. During a concurrent observation and interview on [DATE] at 11:40 AM with Licensed Vocational Nurse 7 (LVN 7), LVN was observed at Resident 6's bedside checking the resident's blood sugar and using glucose test strips from a bottle with an expiration date of [DATE]. LVN 7 stated the glucose test strips are expired and should not have been used for Resident 6's blood sugar test. LVN stated the expired test strips should have been discarded from the medication cart. LVN 7 also stated it was important for all medication equipment that is used to be current and not expired. LVN stated using expired test strips can result in false results of the Resident's blood sugar, causing treatments given to be inaccurate because of the false result. During an interview on [DATE] at 9:45 AM with the Director of Nursing (DON), the DON stated per facility protocol, all glucose test strips being used should not be expired and should be discarded once expired. The DON stated using expired test strips can provide an inaccurate result and the residents may not receive the appropriate interventions like insulin as ordered. During a review of the facility's Policy & Procedure (P&P) titled, Administering Medications, dated 7/2024, the P&P indicated the expiration/beyond use date on the medication label must be checked prior to administering and that medications shall be administered is a safe manner.

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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. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Based on observation, interview, and record review, the facility failed to follow proper sanitation and food handling practices to prevent the outbreak of foodborne illness (food poisoning), by failing to ensure the following:1. Six beef patties that were thawed in the walk-in refrigerator were used within 72 hours or discarded in accordance with the facility policy.2. Kitchen staff wore hairnets and beard restraints (worn by food handlers to avoid getting hair into the food) while preparing food and while dishwashing to prevent loose hair from falling into food or onto surfaces that can come into contact with food.3. Dietary aide used her mouth/teeth to cut the masking tape used to label beverages.4. Dishes and utensils were cleaned under sanitary conditions when dishwasher temperature gauge (a device to monitor temperature) glass cover was obscured making it impossible or difficult to see water temperature gauge readings clearly. These deficient practices had the potential to result in cross contamination (transfer of harmful bacteria [tiny, single-celled living things that are found everywhere, including in and on your body] from one place to another) and harmful bacterial growth and physical contamination (the presence of foreign objects on food that are not supposed to be there, like hair, glass, or metal) that could lead to food borne illness for medically compromised residents (someone whose health status is impaired or weakened, making them more vulnerable to illness or complications) who receive food and use dishes and utensils from the kitchen. Findings:1. During a concurrent observation and interview on 7/21/2025 at 7:42 AM with the Dietary Supervisor (DS) in the walk-in refrigerator, six beef patties in a metal bowl labeled only with date of 7/16/2025, no time was observed being thawed. Beef patties were light brown in color. The DS stated that the thawed beef patties should not be in the refrigerator by this time and should have been cooked by 7/19/2025 or thrown away. The DS stated according to their policy, thawing frozen food was for 72 hours then cooked or if not cooked, it must be discarded. The DS stated the cooks on duty are the ones checking the refrigerators and freezers for food that are ready for cooking or those that are past the thawing time and discard them. The DS stated if the beef patties were cooked past 72 hours and served to the residents, it would be dangerous. The DS stated the residents could get sick and hospitalized . 2. During a concurrent observation and interview on 7/22/2025 at 2:36 PM with Dietary Aide (DA 2) and DA 3, in the kitchen, DA 2 and DA 3 were observed with beards not wearing beard restraints while washing dishes. The DS came and confirmed that both DA 2 and DA 3 had beards and were not wearing beard restraints and stated this was against the facility policy. DA 2 stated he was not instructed to wear a beard restraint while he was working in the kitchen. During a concurrent observation and interview on 7/23/2025 at 8:47 AM with [NAME] 1 and DA 3, in the kitchen, [NAME] 1 was observed by the food preparation area without wearing a hair net. [NAME] 1 stated he went out of the kitchen for his break and forgot to put on a new one when he came back. [NAME] 1 stated he was aware that hairnets should be worn all the times in the kitchen to cover hair to prevent contamination of food being prepared and cooked. [NAME] 1 stated contaminated food can cause illness to the residents in the facility that can lead to hospitalization. DA 3 was simultaneously observed not wearing a beard restraint again. DA 3 stated he was aware that kitchen staff with beards also need to wear beard restraints in addition to wearing hair nets. DA 3 stated he frequently forgets to wear it and forgot to wear it also last Monday, 7/21/2025. DA 3 stated hair can fall into the dishes or food being prepared and contaminate them which could make the residents sick and get hospitalized . 3. During a concurrent observation and interview on 7/21/2025 at 7:49 AM with the DS and DA 1, in the walk-in refrigerator, DA 1 was observed using her mouth/teeth to cut the tape used to write the date and time for the tray containing milk and juice beverages. DA 1 stated she knew that it was not acceptable for her to use her mouth/teeth to cut the tape, but she forgot. DA 1 and DS stated that cutting the tape using the mouth or teeth and then applying to the tray of beverages for the residents, could result in cross contamination that could cause sickness and possible hospitalization to the residents drinking the beverages. 4. During a concurrent observation and interview on 7/23/2025 at 8:15 AM with the DS in the kitchen, the dishwasher water temperature gauge was observed with glass cover appearing opaque making temperature dial obscured making it impossible to read. The DS was asked what the temperature reading was and stated 130 degrees Fahrenheit (a scale for measuring temperature). The DS was asked to check the water temperature again and stated, he cannot really see the numbers and needle gauge and was unable to get accurate reading. The DS stated all plates, trays, cookware, utensils and pitchers and cups are all washed in the dishwasher. The DS stated if the temperature cannot be read accurately, he cannot say that all the items washed in the

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F 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Dispose of garbage and refuse properly. Based on observation, interview and record review, the facility failed to dispose garbage (mostly decomposable food waste or yard waste) and refuse (dry material such as glass, paper, cloth or wood that does not readily decompose) by leaving two of four dumpsters (large trash container designed to be emptied into a truck) exposed to the environment and not cover or close completely. This deficient practice had the potential to attract vermin (animals that are believed to be harmful, carry disease such as rodents, parasitic worms , or insects), pests (any living thing that has a negative effect on humans), and wildlife (undomesticated animal species) that could potentially infiltrate the facility, affect the resident care areas and pose a disease threat to the residents and staff of the facility. Findings:During a concurrent observation and interview on 7/23/2025 at 8:22 AM with the Maintenance Supervisor (MS) at the garbage area, two of four dumpsters were observed with lids left exposed to the environment and not covered or completely closed. The MS confirmed the two dumpsters were full and the lids were not completely closed. The MS stated that dumpsters should be completely closed according to the policy, as pests like flies can get into the trash and potentially go into the facility and which could potentially cause illness to the residents and staff. During a review of the facility's Policy & Procedures (P&P) titled Sanitation and Infection Control: Waste Control and Disposal, dated 2011, the P&P indicated to keep lids of outside trash dumpsters closed.

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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** Based on observation, interview, and record review the facility failed to maintain accurate and complete medical records in accordance with the facility's Policy and Procedures (P&P) for two (2) of 30 sampled residents (Resident 58 and Resident 87) when: Resident 58's intravenous (IV, within the vein) therapy medication record was not initialed on 7/14/2025, 7/15/2025, 7/16/2025, 7/17/2025, 7/18/2025, 7/19/2025, 7/20/2025, 7/21/2025, 7/22/2025 and included inaccurate information on 7/22/2025.Inaccurately documenting the administration of water flushes for one of four sampled residents (Resident 87), in the Medication Administration Record (MAR), when the water flushes were not given. These failures had the potential to result in a lack of or delay in the provision of care/interventions for Residents 87 and 58 and inaccurate communication between healthcare providers. 1. During a review of Resident 58’s admission Record, the admission Record indicated the resident was originally admitted to the facility on [DATE] and readmitted on [DATE]. Resident 58’s diagnoses included extended-spectrum beta-lactamase (ESBL -bacteria that’s resistant to many commonly used antibiotics) resistance, klebsiella (a type of bacteria, commonly found in the human gut and sometimes causing infections), and Alzheimer’s Disease (a disease characterized by a progressive decline in mental abilities). During a review of Resident 58’s Minimum Data Set (MDS-a resident assessment tool), dated 5/28/2025, the MDS indicated Resident 58's cognitive (ability to think and reason) skills for daily decision making were moderately impaired (decisions poor; cues/supervision required). The MDS indicated Resident 58 required partial/moderate assistance (helper does less than half the effort) with eating. The MDS indicated Resident 58 was dependent (helper does all the effort) with oral hygiene, toileting hygiene, shower, upper body dressing, lower body dressing, and putting off footwear. During a review of Resident 58’s Care Plan, initiated 7/15/25, the Care Plan indicated a focus on Resident 58’s IV therapy for ESBL urine and potential for infection and or complications related to IV access (IV site, the specific location on the body where a needle or catheter is inserted into a vein to deliver fluids, medications) and medication administration. The care plan indicated staff interventions were to: Flush IV line as ordered. Observe IV line for any signs and symptoms of complications such as swelling, redness, leakage, and drainage. During a review of Resident 58’s Physician’s Order, dated 7/14/2025, the Physician’s Order indicated Ertapenem (IV antibiotic [ATB, medicines that fight bacterial infections] used to treat various serious bacterial infections by killing or preventing bacterial growth) solution, use 500 milligrams (mg, unit of measurement) every 24 hours for ESBL urine until 7/22/2025. (continued on next page)

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	555908	A. Building B. Wing	07/24/2025

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South Pasadena Care Center	904 Mission St South Pasadena, CA 91030

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of a facility record titled, “IV Therapy Medication Record, “dated 7/2025, the form indicated Resident 58’s IV site check every shift for complications and no adverse reactions from IV therapies unless addressed in nurses’ notes. The IV Therapy Medication Record did not have the initials of the night shift (11 PM – 7 AM) registered nurse on 7/14/2025, 7/15/2025, 7/16/2025, 7/17/2025, 7/18/2025, 7/19/2025, 7/20/2025, 7/21/2025, 7/22/2025 to indicate that Resident 58’s IV site was checked for complications and the resident did not have adverse reactions from IV therapies. During a concurrent observation and interview on 7/21/2025 at 1:56 PM, Resident 58 stated she stopped getting IV medication. Resident 58 stated she does not have an IV line anymore. There was no IV line observed when Resident 58 showed both her wrists and hands. Resident 58 stated the nurses checked her IV site when she was still receiving IV antibiotics to make sure it was in place. During an interview on 7/22/2025 at 3:45 PM with Registered Nurse 2 (RN 2), RN 2 stated she did not check and flush Resident 58’s IV line during her shift on 7/22/2025 7 AM to 3:30 PM. During a follow up record review and interview on 7/22/2025 at 3:50 PM with RN 2, Resident 58’s IV therapy medication record was reviewed. RN 2’s initials were entered on 7/22/25 7 AM to 3:30 PM for Resident 58’s IV therapy maintenance flush, 10 milliliters (ml, unit of measurement) normal saline (a saltwater solution) every 12 hours and site check. RN 2 did not want to explain why her initials were documented. During a concurrent observation in Resident 58’s room and interview on 7/22/2025 at 3:55 PM with RN 2 and RN 3, Resident 58 was observed not to have an IV access. RN 2 and RN 3 verified that Resident 58 has no IV access. RN 3 stated Resident 58 pulled out the IV catheter (a thin plastic tube that is threaded into a vein, flushed with saline, and then capped off for later use) last night (7/21/2025) after the resident was administered IV antibiotic therapy. RN 3 stated she did not document Resident pulled out her IV access last night. During a concurrent record review and interview with MDS nurse (MDSN), Resident 58’s IV therapy medication record was reviewed. MDSN stated Resident 58’s IV therapy medication record has incomplete documentation because the site checks every shift has missing initials of NOC shift (11 PM to 7 AM). The MDSN stated it is important to check the resident’s IV site to make sure that it is still patent, for safety and effective IV treatment. MDSN also added that Resident 58’s IV access should be documented on the record, to know which IV access to check. MDSN stated the Physician (Doctor), allergies and diagnoses for IV boxes was blank (No documentation). MDSN stated it is important to fill up all the boxes in Intravenous Therapy Medication Record for the staff to be aware of what the medication is for, and who’s Physician to call if there’s any questions regarding the IV ATB. During an interview on 7/23/2025 at 8:38 AM with RN 1, RN 1 stated it is important to assess and document IV therapy, including the resident’s tolerance with the IV therapy, and status of IV access. RN 1 stated documenting assessment and writing initials should be after each assessment for accuracy of documentation and to avoid having mistakes. RN 1 stated there should not be any initials on 7/22/2025 for assessing and flushing Resident 58’s IV line because Resident 58 did not have IV access during the shift. RN 1 stated wrong documentation can lead to wrong treatment which might cause harm to any residents. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of facility’s P&P titled, “Continuous Infusion of Medications and Solutions, ” dated March 2023, the P&P indicated the following: · The nurse will monitor the venous access site frequently for signs and symptoms of complications. · Condition of the venous access site will be documented at least every shift with consideration given to prescribed therapy and the condition of the residents. During a review of facility’s P&P titled, “Charting and Documentation,” reviewed on 7/2023, indicated the following: · Documentation in the medical record may be electronic, manual or a combination. The following information is to be documented in the resident medical record: a. Objective observations; b. Medications administered; c. Treatments or services performed; d. Changes in the resident’s condition; e. Events, incidents or accidents involving the resident; and f. Progress toward or changes in the care plan goals and objectives. 2. During a review of Resident 87’s admission Record, the admission Record indicated Resident 87 was admitted to the facility on [DATE], with diagnoses that included gastrostomy status (GTube- a surgical opening fitted with a device to allow feedings to be administered directly to the stomach common for people with swallowing problems), moderate protein-calorie malnutrition (a nutritional deficiency where the body doesn't receive enough protein and calories to meet its needs), and aphasia (a disorder that makes it difficult to speak). During a record review of Resident 87’s “Order Summary Report” dated 5/26/2025, the Order Summary Report indicated an enteral (the administration of substances directly into the gastrointestinal [GI] tract, through a tube) feed order every shift flush tube with 10-15 (cc-a measurement of volume) of water in between each medication administered and flush tube with 30-50 cubic centimeters (cc-a measurement of volume) of fluid before and after medication administration. During a review of Resident 87’s “Minimum Data Set (MDS – a resident assessment tool),” dated 6/6/2025, the MDS indicated resident 87 with severely impaired cognitive skills (ability to understand and make decisions) for daily decision making. The MDS indicated Resident 87 was dependent (helper does all effort needed to complete activity) with oral, toileting and personal hygiene, showering/bathing and dressing. The MDS also indicated Resident 87 had a feeding tube (a small, flexible tube that provides liquid nutrition, fluids and medication to people who are unable to eat or swallow normally), receiving 51% or more calories and 501 cc or more per day, through the feeding tube. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent observation at Resident 87’s bedside and interview on 7/22/2025 from 8:51 AM to 8:59 AM with Licensed Vocational Nurse 3 (LVN 3), LVN 3 was observed flushing Resident 87’s GTube with 5 cc of water in between and after the following medications: a. Gabapentin (medication used to manage certain types of epileptic seizures [sudden surges of abnormal electrical activity in the brain that can cause loss of consciousness, muscle spasm, and changes in sensation, mood, or behavior] and to relieve nerve pain) 100 milligrams (mg- a unit of mass or weight). b. Lisinopril (medication to lower blood pressure) 2.5 mg. c. Levetiracetam (medication used to treat and prevent seizures) 500 mg/ 5 milliliters (ml – a measurement of volume). d. Aspirin (medication that works by making the blood less sticky) 81 mg. LVN 3 stated he flushed 5 cc of water between each of Resident 87’s medications during the administration and 5 cc after all medications were given. During a concurrent interview and record review on 7/23/2025 at 3:39 PM with LVN 3, Resident 87’s “MAR,” dated 7/1/2025 to 7/31/2025, was reviewed. The MAR indicated 10 to 15cc of water flush was administered between each medication and 30 to 50 cc of fluid was administered after medication administration on 7/22/2025 during the day shift. LVN 3 stated the MAR shows the water flushes were administered by LVN 9 on 7/22/2025 but LVN 3 stated he administered the water flushes so he should have signed it. LVN 3 added, MAR documentation needs to be accurate to ensure the residents are given the flushes as ordered and the health care team are aware if they were not given. During an interview on 7/23/2025 at 4:06 PM with LVN 9, LVN 9 stated she did not administer any water flushes to Resident 87 on 7/22/2025. LVN 9 stated Resident 87’s MAR was inaccurate, and it is important for documentation to be correct and accurate per policy to make sure residents receive all medications and water flushes as prescribed. During an interview on 7/24/2025 at 10:05 AM with the Director of Nursing (DON), the DON stated only nurses administering the water flushes are to document on the MAR for administration. The DON stated it was important for accurate documentation because the health care providers rely on the documentation of other providers to see the accurate and current condition of the patient and administered treatments or not. The DON stated if the documentation is inaccurate, the facility cannot ensure the right interventions are provided to the resident or the wrong treatments can be provided. During a review of the facility’s policy & procedure (P&P) titled, “Charting and Documentation, ” dated 7/2023, the P&P indicated documentation in the medical record will be objective, complete and accurate.

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** Based on interview and record review, the facility failed to ensure a coordination of care between the facility and hospice (care designed to give supportive care to people in the final phase if a terminal illness and focus on comfort and quality of life, rather than cure) staff for two of two sampled residents (Resident 14 and Resident 105) in accordance with the physician's order by failing to ensure:1. Resident 14 has a July 2025 Hospice nursing visitation calendar and hospice care in June 2025 was provided as indicated on the physician's order. 2. Hospice visits for June 2025 and July 2025 were provided for Resident 105. This deficient practice had the potential for Resident 14 and Resident 105 not to receive the hospice care and services necessary to promote comfort and quality of life. Findings: 1. During a review of Resident 14’s admission Record, the admission Record indicated the facility admitted Resident 14 on 12/9/2024, with diagnoses including, but not limited to cerebral infarction (or stroke-an interruption in the flow of blood to cells in the brain) and intracerebral hemorrhage (bleeding that occurs within the brain tissue itself. This can cause damage to the brain and potentially lead to loss of consciousness and even death). During a review of Resident 14’s Minimum Data Set (MDS-a resident assessment tool), dated 6/19/2025, the MDS indicated Resident 14 had severely impaired cognitive skills (ability to think, understand, and reason) for daily decision making. The MDS indicated Resident 14 was dependent (Helper does all the effort. Resident does none of the effort to complete the activity, or the assistance of two or more helpers is required for the resident to complete the activity) with oral, toileting and personal hygiene, showering/bathing self, upper and lower body dressing, and putting on and taking off footwear. Resident 14 was assessed as receiving hospice services. During a review of Resident 14’s Order Summary dated, 7/23/2025, the Order Summary indicated Resident 14 was admitted to hospice care on 12/13/2024 with diagnosis of cerebral infarction, under the care of Hospice doctor (Hospice MD 2). During a concurrent interview and record review on 7/23/2025 at 9:53 AM with the MDS Nurse (MDSN), the hospice binder was reviewed. The hospice binder indicated Hospice Calendar Visits for certification period 6/11/2025 to 8/9/2025, Nurse Aid (NA) coordination notes from 5/22/2025 to 7/22/2025, and hospice visit calendar and sign in sheet for the month of June 2025. The MDSN stated hospice visits were as follows: Registered Nurse (RN) or Licensed Vocational Nurse (LVN) – once a week Social Worker (SW) - once a week NA - twice a week (continued on next page)

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The MDSN stated that the sign-in sheet for visits, care notes from RN, LVN, NA and SW were incomplete. The MDSN stated only the June 2025 visit calendar/sign in was in the chart. MDSN stated there was no hospice nursing visitation calendar for July 2025. MDSN stated the only initials were for SW signed on 6/30/2025 and there were none for RN, LVN and NA. The MDSN stated that according to the Hospice agreement with the facility, when hospice staff come in to visit the resident, they should sign in on the hospice nursing visitation calendar. The MDSN stated the agreement was not followed as hospice staff sign-in were not reflected on the hospice nursing visitation calendar. The MDSN stated that if there was no documentation and endorsement, facility staff were not aware if the visits occurred and what transpired during the visit. During a review of the Hospice Agreement, dated 7/9/2025, the Hospice Agreement under Joint Responsibilities/Mutual Promises indicated Hospice and Facility shall jointly develop and agree upon the patient’s plan of care. Hospice and Facility each shall maintain appropriate documentation of services provided under this agreement in accordance with applicable state and federal law and regulations and accreditation standards. During a review of the facility’s Policy and Procedure (P&P) titled “Hospice Program,” revised 9/2023, indicated: 1. It is the responsibility of the facility to meet the resident’s personal care and nursing needs in coordination with the hospice representative and ensure that the level of care provided is appropriately based on the individual resident's needs including communicating with the hospice provider (and documenting such communication) to ensure the needs of the residents are addressed and met 24 hours per day. 2. Our facility has designated the facility Social Services Designee and/or Director of Nursing to coordinate care provided to the resident by our facility staff and the hospice staff. a. Collaborating with hospice representatives and coordinating facility staff participation in the hospice care planning process for residents receiving these services; b. Communicating with hospice representatives and other healthcare providers participating in the provision of care for the terminal illness, related conditions, and other conditions, to ensure quality of care for the resident and family. c. Ensuring that our facility staff provides orientation on the policies and procedures of the facility, including resident rights, appropriate forms, and record keeping requirements, to hospice staff furnishing care to the residents. 3. Coordinated care plans for residents receiving hospice services will include the most recent hospice plan of care as well.as the care and services provided by our facility (including the responsible provider and discipline assigned to specific tasks) in order to maintain the resident's highest practicable physical, mental and psychosocial well-being. (continued on next page)

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. During a review of Resident 105's admission Record, the admission Record indicated the resident was originally admitted to the facility on [DATE], with diagnoses that included Alzheimer’s disease (a progressive brain disorder that gradually impairs thinking, memory, and the ability to carry out daily tasks), hemiplegia and hemiparesis following nontraumatic intracranial hemorrhage affecting right dominant side (the development of weakness or paralysis on the right side of the body as a result of bleeding within the brain that was not caused by injury), and dementia (the loss of cognitive functioning, thinking, remembering, and reasoning to such an extent that it interferes with a person's daily life and activities). During a review of Resident 105's Minimum Data Set (MDS- a mandated resident assessment tool), dated 6/4/2025, the MDS indicated Resident 105 had severe impairment for cognitive skills (the function of the brain uses to think, pay attention, process information, and remember things) for daily decision making. Resident 105 was dependent on all for oral hygiene, personal hygiene, toileting hygiene, shower/bathe self, upper and lower body dressing, change of position, and transfer. During a review of Resident 105's Physician’s Order (PO) dated 2/18/2025, the PO indicated Resident 105 was admitted to hospice care starting 2/18/2025 under routine care of hospice doctor, (hospice MD) for diagnosis of Alzheimer’s disease. During a concurrent interview and record review with the MDS nurse (MDSN) on 7/23/2025 at 9:33 AM, Resident 105’s hospice June 2025 and July 2025 hospice visiting calendar and sign in form were reviewed. MDSN stated she was not sure if the HRN came to visit Resident 105 on 6/8/2025, 6/22/2025, 7/6/2025 and 7/20/2025 as indicated on the hospice visiting calendar because the sign in sheet was not signed. MDSN stated she was not sure if the Licensed Vocational Nurse (LVN) came to visit Resident 105 on 6/5/2025, 6/12/2025, 6/19/2025, 6/26/2025, 7/3/2025, 7/10/2025 and 7/17/2025 as indicated on the per hospice visiting calendar because the sign in sheet was not signed. MDSN stated there were no LVN visiting notes for these dates. MDSN stated if there were no sign in from the hospice nurses then the visit was not done. MDSN stated the hospice visits should have been conducted in accordance with the hospice agreement. During an interview with LVN 5 on 7/23/2025 at 10:00 AM, LVN 5 stated he did not see Resident 105’s HRN for quite a while. LVN 5 stated he had never seen any hospice LVN visit Resident 105. During an interview with LVN 9 on 7/23/2025 at 10:09 AM, LVN 9 stated she did not recognize or have seen any hospice nurses visiting Resident 105. During an interview with the Medical Records Director (MRD) on 7/24/2025 at 10:29 AM, MRD stated she was unable to find Resident 105's hospice notes and sign in information from HRN dated 6/8/2025, 6/22/2025, 7/6/2025 and 7/20/2025. MRD stated there were no LVN visiting notes and sign in information for 6/5/2025, 6/12/2025, 6/19/2025, 6/26/2025, 7/3/2025, 7/10/2025 and 7/17/2025 can be found anywhere else. During an interview with Director of Nursing (DON) on 7/24/2025 at 10:46 AM, the DON stated he was aware that MDSN is the designated person for hospice coordination. The DON stated the facility should have ensured that facility staff and hospice staff worked collaboratively, and assured the communication process was in place between the facility staff and hospice staff. The DON stated the facility should have ensured that hospice staff provided nursing/visitation notes and signed in on the hospice form as projected on the visiting schedule calendar in accordance with the hospice agreement. (continued on next page)

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility's policy and procedure (P&P) titled Hospice Program, revised September 2023, indicated It is the responsibility of the facility to meet the resident’s personal care and nursing needs in coordination with the hospice representative and ensure that the level of care provided is appropriately based on the individual resident's needs including to communicate with the hospice provider (and documenting such communication) to ensure the needs of the residents are addressed and met 24 hours per day. Our facility has designated the facility Social Services Designee and/or Director of Nursing to coordinate care provided to the resident by our facility staff and the hospice staff. a. Collaborating with hospice representatives and coordinating facility staff participation in the hospice care planning process for residents receiving these services; b. Communicating with hospice representatives and other healthcare providers participating in the provision of care for the terminal illness, related conditions, and other conditions, to ensure quality of care for the resident and family. c. Ensuring that our facility staff provides orientation on the policies and procedures of the facility, including resident rights, appropriate forms, and record keeping requirements, to hospice staff furnishing care to the residents. Coordinated care plans for residents receiving hospice services will include the most recent hospice plan of care as well.as the care and services provided by our facility (including the responsible provider and discipline assigned to specific tasks) in order to maintain the resident's highest practicable physical, mental and psychosocial well-being.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. 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 or diseases in the healthcare setting) was followed when medical waste (any waste generated by healthcare activities, ranging from used needles [the pointed hollow end of a syringe[medical device consisting or a hollow tube with a plunger]] and syringes to soiled dressings, body parts, blood, and medical devices) was not disposed safely and appropriately in accordance with the facility's policy and procedure (P&P). This deficient practice had the potential to result in the spread of and development of infection through possible cross contamination (passing of bacteria or other harmful substances indirectly from one resident to another through improper disposal of medical waste.Findings: During a concurrent observation and interview on 7/23/2025 at 10:30 AM with Licensed Vocational Nurse (LVN 4), inside Room B, LVN 4, performed wound care treatment. A sacral area wound (skin injury that develops in the area near the tailbone and lower back, due to prolonged pressure) was observed bleeding profusely (in large amounts). LVN 4 was observed discarding the soiled dressing, gauze saturated with blood, and other materials used to clean the wound in a clear plastic bag. LVN 4 stated she used a separate clear plastic bag to discard the soiled dressing and bloody gauze and will discard it in a separate black bin, not together with the regular trash. LVN 4 also stated the resident was previously on contact isolation (a type of precaution used in healthcare settings to prevent the spread of infections that are easily transmitted through direct or indirect contact with a patient or their environment) for a stage four pressure ulcer of the sacrum but contact isolation was discontinued on 7/21/2025. During an interview with the Infection Control Nurse (IPN), the IPN stated no red bags were needed to discard the medical waste from the resident in Room B, as the contact isolation was already discontinued. The IPN stated the facility is following Centers for Disease Control and Prevention (CDC) guidelines that contact isolation can be discontinued even if the antibiotic course was not completed yet and if wounds still have secretions or bleeding as long as the contact isolation order has been discontinued. The IPN further stated that the facility does not have color coded bin/containers for medical or hazardous waste. During a concurrent interview and record review on 7/24/2025 with the IPN, the P&P titled, Medical Waste, handling of, with review date of January 2025 was reviewed. The P&P's purpose was to provide a definition of and guidelines for the safe and appropriate handling of medical waste. The P&P also indicated:1. For the purpose of this policy, medical waste includes human blood and blood-soiled articles, contaminated items (i. e., soiled dressings), items contaminated with feces from a person diagnosed as having a disease that is transmitted through feces, and disposable sharps (i.e., needles/scalpels).2. Disposable items soiled with visible blood (or feces from a resident with a disease transmitted through feces) must be placed in red plastic bags or containers, and a solution of one part bleach and nine parts water added to saturate the item or items must be incinerated.The IPN again stated the facility has no color coded or colored bins to separately dispose of medical wastes. The IPN stated that it was important that hazardous/medical wastes were disposed of safely and appropriately to prevent contamination and spread of infection.

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. Based on observation, interview, and record review, the facility failed to:1. Clean the dryer lint trap for one (1) of four (4) dryers located in the laundry room as indicated in the Facility's Policy and Procedures (P&P). This deficient practice had the potential to cause fire in the facility. 2. Ensure laundry washer temperature was accurately checked on 7/23/2025. This deficient practice had the potential of improper disinfection of residents' clothes. 3. Ensure restroom A and room A were free of urine on the toilet surfaces and floor. This deficient practice had the potential to affect resident's quality of life. 1. During a concurrent observation in the laundry room and interview with Laundry Staff 1 (LS 1) and Infection Prevention Nurse (IPN) on 7/23/2025 at 1:09 PM, 4 dryers were observed in the laundry room. Lint found in the lint traps in 1 dryer (dryer 1). LS 1 stated, Lint is removed from the lint traps every two (2) hours, and it is being logged. IPN verified that lint was found in the lint trap in dryer 1. IPN stated the log indicated a schedule of 6 AM, 8 AM, 10 AM, 12 PM, and 2 PM. During a concurrent record review and interview on 7/23/2025 at 1:10 PM with LS 2, the Lint removal log for July 2025 was reviewed. LS 2 stated 7/23/2025 12 PM log was blank. LS 2 stated he did not know why it is still blank. 2. During a concurrent record review and interview on 7/23/2025 at 1:11 PM with LS 2, the laundry water temperature log for July 2025 was reviewed. LS 2 stated the log indicated to check washer water temperature at 6 AM, 10 AM and 2 PM. The Maintenance Supervisor (MS) verified the 7/23/25 at 2 PM log already has a reading of 160 Fahrenheit (unit of measurement). LS 2 stated, “It is future dated. ” During an interview on 7/24/2025 at 10:04 AM, MS stated leaving the lint in the lint traps can cause fires and was unsanitary. MS stated it is important to follow and log the water temperature on the scheduled time to make sure the washers have the right temperatures when washing the residents’ clothes. The MS stated that not documenting on the scheduled time of lint removal and documenting at a future time of water temperature reading is inaccurate because the schedule is not being followed. During a review of facility's undated Policy and Procedure (P&P) titled, “Maintenance of the Laundry Room and Laundry Equipment,” indicated “Clean lint filters after each use of washer or dryer every three (3) hours.” During a review of facility’s undated P&P titled, “Laundry Water Temperature,” indicated “The Laundry personnel will maintain a log of daily laundry water temperatures to ensure that water is maintained at the appropriate temperature to provide proper disinfection of soiled linen.” 3. During an observation on 7/21/2025 at 9:27 AM in Restroom A and Room A, yellow-brownish fluid was seen on the surfaces on the toilet seat riser chair (an assistive device that elevates the height of a toilet seat making it more accessible for individuals who have difficulty bending or have limited range of motion in their hips and knees) and the floor, leading from the toilet base inside of Restroom A to the flooring inside of Room A. (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	07/24/2025

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 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 7/24/2025 at 8:57 AM with IPN, IPN stated urine on the surfaces of the “high rise chair” and floor is not sanitary and can be a breach of infection control. During an interview on 7/24/2025 at 10:02 AM with the DON, DON stated facility is to ensure that resident rooms and bathrooms are clean and safe because it is their home. DON stated having urine on the toilet and floor is not sanitary and not safe because residents, staff or visitors can slip and fall. During a review of the facility’s policy and procedure (P&P) titled “Homelike Environment, ” dated 6/2024, the P&P indicated residents are provided with a safe, clean, comfortable and homelike environment, facility staff and management maximizes, to the extent possible, clean sanitary and orderly environment.