STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555213	A. Building B. Wing	01/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pasadena Care Center, LLC	1640 N. Fair Oaks Avenue Pasadena, CA 91103

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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49537 Based on observation, interview and record review, the facility failed to ensure accurate assessment of oxygen (O2) use for three of three sampled residents (Residents 4, 5 and 6) on the Minimum Data Set (MDS- a resident assessment tool) as indicated on the facility policy. This deficient practice had the potential for the facility to not develop and implement an individualized care plan for Residents 4, 5, and 6, which could negatively affect the resident's overall wellbeing. Findings: 1. During a review of Resident 4's Admission Record, the Admission Record indicated the facility initially admitted the resident on 9/2/2024 and was readmitted on [DATE] with diagnoses that included, but not limited to end stage renal disease (ESRD-irreversible kidney failure) requiring hemodialysis (a treatment to cleanse the blood of wastes and extra fluids artificially through a machine when the kidneys have failed), type II diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing), congestive heart failure (CHF-a heart disorder which causes the heart to not pump the blood efficiently, sometimes resulting in leg swelling), sleep apnea (a sleep disorder characterized by pauses in breathing during sleep), dependence on supplemental oxygen therapy (a treatment that provides extra oxygen to people who have breathing problems or low oxygen levels in their blood) and methicillin resistant staphylococcus aureus blood stream infection (MRSA bacteremia-a severe infection that occurs when MRSA is present in the blood and a bacteria that does not respond to antibiotics). During a review of Resident 4's MDS, dated [DATE], the MDS indicated Resident 4 had moderate impairment with cognitive (mental processes that take place in the brain, including thinking, attention, language learning, memory, and perception skills for daily decision making) skills for daily decision making. The MDS also indicated Resident 4 required partial/moderate assistance (Helper lifts, holds, or supports trunk or limbs but provides less than half the effort) with eating. MDS also indicated Resident 4 required substantial/maximal assistance (Helper lifts or holds trunk or limbs and provides more than half the effort) with oral, personal hygiene and upper body dressing. The MDS further indicated Resident 4 was dependent (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 toileting hygiene, showering/bathing self, lower body dressing and putting on/taking off footwear. The MDS did not indicate the use of oxygen. (continued on next page)

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation on 1/2/2024 at 5:40 AM at Resident 4's room, Resident 4 was still asleep, on O2 at 1. 5 liters per minute (LPM-unit of measurement for oxygen a patient receives) via nasal cannula (NC-a small plastic tube, which fits into the person's nostrils for providing supplemental oxygen). During a concurrent interview and record review on 1/3/2025 at 9:12 AM with MDS Nurse (MDSN), the Medical Doctor (MD) order, MDS dated [DATE] and Care plan for Resident 4 were reviewed. MDSN stated there was an MD order for O2 use since Resident was admitted back in 9/2024. MDSN stated the MDS assessment which included identification of any special treatments, procedures, and programs received or performed during the assessment period did not reflect Resident 4's O2 therapy. MDSN stated there was no care plan initiated for O2 therapy. MDSN further stated she did not properly assess the resident during the look back period. MDSN stated she should have included Resident 4's use of oxygen in the MDS. 2. During a review of Resident 5's Admission record, the Admission Record indicated the facility initially admitted Resident 5 on 4/1/2024 and was readmitted on [DATE] with diagnoses that included, but not limited to acute respiratory failure with hypoxia (occurs when the lungs [pair of organs in the chest that help you breathe] have trouble exchanging oxygen with the blood, resulting in low oxygen levels in the body's tissues), dementia (chronic condition that causes a person to lose cognitive functioning such as thinking, remembering, and reasoning to the point that it interferes with daily life), subarachnoid hemorrhage (bleeding that occurs in the space between your brain and the membrane that covers it), presence of gastrostomy (surgical opening fitted with a device to allow feedings to be administered directly to the stomach common for people with swallowing problems), quadriplegia (paralysis from the neck down, including legs, and arms, usually due to a spinal cord injury), and dependence on supplemental oxygen therapy (a treatment that provides extra oxygen to people who have breathing problems or low oxygen levels in their blood). During a review of Resident 5's MDS, dated [DATE], the MDS indicated Resident 5 had severe impairment with cognitive skills for daily decision making and was dependent with eating, oral/toileting/personal hygiene, shower/bathing self, upper and lower body dressing, and putting on/taking off footwear. The MDS did not indicate the use of oxygen. During a record review on 1/2/2025 at 7:10 AM with Licensed Vocational Nurse 1 (LVN 1), the MD order was reviewed. LVN 1 stated Resident 5's O2 order indicated at 2 LPM via nasal cannula for shortness of breath (SOB), wheezing (a high-pitched sound made when breathing is restricted/obstructed in the lungs), chest pain, Oxygen saturation (O2 sat- percentage of oxygen carried by red blood cells in the bloodstream. A resting O2 sat level between 95% to 100% is regarded as normal for a healthy person at sea level) less than 90% room air and notify the doctor. The order was not as needed or pro re nata (PRN-given as needed or requested). During an observation on 1/2/2025 at 7:18 AM in Resident 5's room, with LVN 1, observed O2 level was at 4 LPM via NC. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review on 1/3/2025 at 9:20 AM with MDSN, MD order, MDS dated [DATE] and Care plan for Resident 5 were reviewed. MDSN stated there was an MD order for O2 use on 10/26/2024. MDSN stated the MDS assessment which included identification of any special treatments, procedures, and programs received or performed during the assessment period did not reflect Resident 5's O2 therapy. MDSN stated there was no care plan initiated for O2 therapy. MDSN further stated she did not properly assess the resident during the look back period. MDSN stated she should have included Resident 5's use of oxygen in the MDS. 3. During a review of Resident 6's Admission Record, the Admission Record indicated the facility initially admitted the resident on 5/7/2021 and was readmitted on [DATE] with diagnoses that included, but not limited to chronic obstructive pulmonary disease (COPD- a chronic lung disease causing difficulty in breathing) and heart failure (also known as CHF). During a review of Resident 6's MDS, dated [DATE], the MDS indicated Resident 6 had intact cognitive skills for daily decision making. The MDS also indicated Resident 6 required partial/moderate assistance with eating, substantial/maximal assistance with oral and personal hygiene and upper body dressing. The MDS further indicated the resident was dependent with toileting hygiene, showering/bathing self, lower body dressing and putting on/taking off footwear. The MDS did not indicate the use of oxygen. During a record review on 1/2/2025 at 7:20 AM with LVN 1, Resident 6's MD order for O2 was reviewed. LVN 1 stated the order indicated 2LPM via NC for SOB, wheezing, chest pain, O2 sat less than 90% room air and notify the doctor. The order was not PRN. During an observation on 1/2/2025 at 7:46 AM at Resident 6's room with RN 2, O2 level was observed at 5LPM via NC. During a concurrent interview and record review on 1/3/2025 at 9:30 AM with MDSN, MD order, MDS dated [DATE] and Care plan for Resident 6 were reviewed. MDSN stated there was an MD order for O2 use on 7/15/2024. MDSN stated the MDS assessment which included identification of any special treatments, procedures, and programs received or performed during the assessment period did not reflect Resident 6's O2 therapy. MDSN stated there was no care plan initiated for O2 therapy. MDSN further stated she did not properly assess the resident during the look back period. MDSN stated she should have included Resident 6's use of oxygen in the MDS. During an interview on 1/3/2025 at 9:45 AM with MDSN, MDSN stated the MDS should accurately reflect O2 therapy status. MDS stated that it was important to have an accurate comprehensive assessment of each resident since the MDS is transmitted to the Centers for Medicare and Medicaid Services (CMS) and helps nursing home staff identify health problems. During a review of the facility's policy and procedure (P&P) titled, Resident Assessments, revised 12/2024, the P&P indicated the resident assessment coordinator (or MDSN) is responsible for ensuring that the interdisciplinary team conducts timely and appropriate resident assessments. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility's P&P titled, Policy and Procedure on Documentations, dated 12/2024, the P&P indicated that it is the policy of the facility to document all pertinent data and information of each resident in their respective medical record. The P&P also indicated that documentations should reflect all findings after assessment was done and reflect concern or problems of the resident.

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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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 46087 Based on observation, interview, and record review, the facility failed to provide padded side rails (metal or plastic bars positioned along the side of a bed) as indicated on the physician's order for one of two sampled Residents (Resident 3) who has a diagnosis of seizure (a sudden, uncontrolled electrical disturbance in the brain which can cause uncontrolled jerking, blank stares, and loss of consciousness). This failure had the potential for Resident 3 to sustain an injury or harm in an event of a seizure episode. Findings: During a review of Resident 3's Admission Record, the Admission Record indicated the facility admitted Resident 3 on 1/31/2003. Resident 3's diagnoses included seizure, schizophrenia (a mental illness that is characterized by disturbances in thought), and repeated falls. During a review of Resident 3's Minimum Data Set (MDS - a resident assessment tool) dated 12/11/2024, the MDS indicated Resident 3 was moderately impaired (decisions poor; cues/supervision required) with cognitive (processes of thinking and reasoning) skills for daily decision making. The MDS indicated Resident 3 required supervision (helper provides verbal cues) with eating, oral hygiene, toileting hygiene, and personal hygiene. The MDS indicated Resident 3 required partial/moderate assistance (helper does less than half the effort) with shower/bathe self, upper body dressing, lower body dressing and putting on/taking off footwear. The MDS indicated Resident 3 has a diagnosis of seizure disorder. During a review of Resident 3's Order Summary Report, dated 1/2/2025, timed 1:17 PM, the Order Summary Report indicated an order to may use padded (cushion) one fourth (1/4) side rail at upper bilateral (both) sides as non-restrictive device for seizure precaution (a measure taken in advance to prevent something dangerous, unpleasant, or inconvenient from happening), ordered on 11/28/2023. During a review of Resident 3's Care Plan titled, Resident (Resident 3) uses padded 1/4 side rails at upper bilateral sides as non-restrictive device for seizure precaution, revised on 7/31/2024, the care plan indicated staff interventions were the following: may use padded 1/4 side rails at upper bilateral sides as non-restrictive device for seizure precaution. Provide frequent staff monitoring when resident in bed and side rails are used. Re-evaluate the need for the bed rails. During a review of Resident 3's Physical Restraint Assessment, dated 12/10/2024, the Physical Restraint Assessment indicated a use of 1/4 length both side rails for enabler (assist with movement) due to associated diagnosis and for seizure precaution. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 1/2/2025 at 6:34 AM in Resident 3's room, Resident 3's bed has no side rails. During a concurrent observation and interview on 1/3/2025 at 6:55 AM with Licensed Vocational Nurse 1 (LVN 1) in Resident 3's room, LVN 1 stated Resident 3 has no side rails because Resident 3 does not need it. During a concurrent interview and record review on 1/3/2025 at 6:58 AM with LVN 1, Resident 3's active orders were reviewed. LVN 1 stated Resident 3 has order for padded side rails for seizure precautions. LVN 1 verified Resident 3 has a seizure disorder. LVN 1 stated it was important to have padded side rails to prevent any injuries when residents have seizure episodes. During a concurrent observation and interview on 1/3/2025 at 11:45 AM with LVN 3 in Resident 3's room, Resident 3 was observed sleeping in bed with side rails up. LVN 3 stated it was her first time to see Resident 3's bed with side rails. LVN 3 verified that the side rails were not padded and should have been padded because Resident 3 has a seizure disorder. During an interview on 1/3/2025 at 12:40 PM with MDS nurse (MDSN), MDSN stated padded side rails is important for residents with seizure disorder to prevent injury in an event of seizure episodes. During a concurrent interview and record review on 1/3/2025 at 1 PM with Registered Nurse 3 (RN 3), RN 3 verified Resident 3 has a physician's order for padded 1/4 siderails at upper bilateral sides for seizure precaution since 11/28/2023. RN 3 stated it is important for Resident 3 to have padded side rails because if Resident 3 has a seizure episode, unpadded side rails might cause trauma to Resident 3's body parts. RN 3 stated they should have checked Resident 3 periodically to make sure padded side rails were implemented. During a review of Facility's undated Policy and Procedure titled, Policy and Procedures on Side Rails, the Policy and Procedure indicated Padding of side rails may be required to protect resident from any injury as a result of the use of side rails, such as skin irritation and/or skin tear due to unnecessary, involuntary body movement secondary to some medical problems or diagnosis. It includes but not limited to those who are having seizure activity.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49537 Based on observation, interview, and record review, the facility failed to provide the necessary respiratory care services for three (3) of 3 sampled residents (Residents 4, 5, and 6) by failing to: a. Ensure oxygen (O2, a colorless, odorless gas necessary for most living organisms to breathe and function properly) was administered to the residents via nasal cannula (NC- a small plastic tube, which fits into the person's nostrils for providing supplemental oxygen) according to the physician's orders. b. Label the humidifier (medical devices that increase the humidity in your oxygen while using supplemental oxygen. These devices look like water bottles and have a special cap with a wing nut on top used for attaching the humidifier to an oxygen concentrator.) with resident's name and date as indicated in the facility's oxygen policy and procedure (P&P). These deficient practices placed Resident 4, 5, and 6 at risk for experiencing complications such as respiratory distress (a condition that occurs when the body needs more oxygen, resulting in difficulty breathing, rapid breathing, and low blood oxygen level) that can lead to serious illness and/or death. Findings: 1. During a review of Resident 4's Admission Record, the Admission Record indicated the facility initially admitted the resident on 9/2/2024 and was readmitted on [DATE] with diagnoses that included, but not limited to end stage renal disease (ESRD-irreversible kidney failure) requiring hemodialysis (a treatment to cleanse the blood of wastes and extra fluids artificially through a machine when the kidneys have failed), type II diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing), congestive heart failure (CHF-a heart disorder which causes the heart to not pump the blood efficiently, sometimes resulting in leg swelling), sleep apnea (a sleep disorder characterized by pauses in breathing during sleep), dependence on supplemental oxygen therapy (a treatment that provides extra oxygen to people who have breathing problems or low oxygen levels in their blood) and methicillin resistant staphylococcus aureus blood stream infection (MRSA bacteremia-a severe infection that occurs when MRSA is present in the blood and a bacteria that does not respond to antibiotics). During a review of Resident 4's Minimum Data Set (MDS-a resident assessment tool) dated 12/16/2024, the MDS indicated Resident 4 had moderate cognitive (mental processes that take place in the brain, including thinking, attention, language learning, memory, and perception skills for daily decision making) impairment. The MDS also indicated Resident 4 required partial/moderate assistance (Helper lifts, holds, or supports trunk or limbs but provides less than half the effort) with eating. MDS also indicated resident required substantial/maximal assistance (Helper lifts or holds trunk or limbs and provides more than half the effort) with oral, personal hygiene and upper body dressing. The MDS further indicated the resident was dependent (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 toileting hygiene, showering/bathing self, lower body dressing and putting on/taking off footwear. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation on 1/2/2024 at 5:40 AM at Resident 4's room, Resident 4 was asleep and was on oxygen at one and a half (1.5) liters per minute (LPM-unit of measurement for oxygen a patient receives) via NC. There was no label with resident's name and date on the humidifier. During a review of Resident 4's Physician's order, dated 12/30/2024, the Physician's order indicated O2 at 2 LPM via NC for shortness of breath (SOB), wheezing (a high-pitched sound made when breathing is restricted/obstructed in the lungs), chest pain, and O2 saturation (O2 sat- percentage of oxygen carried by red blood cells in the bloodstream. A resting O2 sat level between 95% to 100% is regarded as normal for a healthy person at sea level) for less than 90% room air. During a concurrent observation and interview on 1/2/2025 at 7:03 AM at Resident 4's room with Licensed Vocational Nurse 1 (LVN 1), LVN 1 stated that the oxygen level was at 1.5 LPM. LVN 1 stated the order was two to three (2-3) LPM. During a concurrent interview and record review on 1/2/2025 at 7:10 AM with LVN 1, Resident 4's Physician Order, Nurses' Progress Notes and Care Plans were reviewed. LVN 1 stated the O2 order indicated 2 LPM via NC for SOB, wheezing, chest pain, O2 saturation less than 90% room air and notify the doctor. LVN 1 further stated, the order was not as needed or pro re nata (PRN-given as needed or requested). LVN 1 stated there was no documentation that O2 level was changed, no documentation of physician notification and there was no care plan for O2 therapy in Resident 4's records. LVN 1 stated if Resident 4 was not on the prescribed O2 level, resident can desaturate and become hypoxic (having a low level of oxygen) and transferred to the acute care hospital. 2. During a review of Resident 5's Admission record, the Admission Record indicated the facility initially admitted Resident 5 on 4/1/2024 and was readmitted on [DATE] with diagnoses that included, but not limited to acute respiratory failure with hypoxia (occurs when the lungs [pair of organs in the chest that help you breathe] have trouble exchanging oxygen with the blood, resulting in low oxygen levels in the body's tissues), dementia (chronic condition that causes a person to lose cognitive functioning such as thinking, remembering, and reasoning to the point that it interferes with daily life), subarachnoid hemorrhage (bleeding that occurs in the space between your brain and the membrane that covers it), presence of gastrostomy (surgical opening fitted with a device to allow feedings to be administered directly to the stomach common for people with swallowing problems), quadriplegia (paralysis from the neck down, including legs, and arms, usually due to a spinal cord injury), and dependence on supplemental oxygen therapy (a treatment that provides extra oxygen to people who have breathing problems or low oxygen levels in their blood). During a review of Resident 5's MDS, dated [DATE], the MDS indicated Resident 5 had severely impaired cognitive skills for daily decision making and was dependent with eating, oral/toileting/personal hygiene, shower/bathing self, upper and lower body dressing, and putting on/taking off footwear. During a review of Resident 5's Physician's order, dated 10/26/2024, the Physician's order indicated O2 at 2 LPM via NC for SOB, wheezing, chest pain, O2 saturation less than 90% room air and notify the doctor as needed. During an observation on 1/2/2025 at 7:18 AM in Resident 5's room with LVN 1, the O2 level was observed at 4 LPM via NC and there was no label with resident's name and date on the humidifier. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review on 1/2/2025 at 7:20 AM with LVN 1, Resident 5's Physician Order for O2, Nurses' Progress Notes and Care Plans were reviewed. LVN 1 stated the order indicated 2LPM via NC for SOB, wheezing, chest pain, O2 sat less than 90% room air and notify the doctor. The order was not PRN. LVN 1 also stated, she did not check the O2 level at the start of her shift and could not find documentation that Resident 5's O2 was increased, what the cause was and if the physician was notified. LVN 1 further stated there was no care plan addressing O2 therapy in Resident 5's records and O2 level cannot be decreased or increased without physician's orders. 3. During a review of Resident 6's Admission Record, the Admission Record indicated the facility initially admitted the resident on 5/7/2021 and was readmitted on [DATE] with diagnoses that included, but not limited to chronic obstructive pulmonary disease (COPD- a chronic lung disease causing difficulty in breathing) and heart failure (also known as CHF). During a review of Resident 6's MDS, dated [DATE], the MDS indicated Resident 6 had intact cognitive skills for daily decision making. The MDS also indicated Resident 6 required partial/moderate assistance with eating, substantial/maximal assistance with oral and personal hygiene and upper body dressing. The MDS further indicated the resident was dependent with toileting hygiene, showering/bathing self, lower body dressing and putting on/taking off footwear. During a review of Resident 6's Physician's order, dated 7/15/2024, the Physician's order indicated O2 at 2 LPM via NC for SOB, wheezing, chest pain, and to keep O2 saturation above 92%. May increase to 3 LPM via NC if not contraindicated and if oxygen level decreased to less than 90% every shift. During an observation on 1/2/2025 at 7:46 AM at Resident 6's room with RN 2, O2 level was observed at 5LPM via NC. RN 2 verified that level was at 5LPM and there was no label with resident's name and date on the humidifier. During a concurrent interview and record review on 1/2/2025 at 8:03 AM with RN 2, Resident 6's Physician Order, Nurses' Progress Notes and care plans were reviewed. RN 2 stated order indicated 2LPM via NC for SOB, wheezing, chest pain and to keep O2 sat above 92%. May be increased to 3LPM if not contraindicated and if O2 sat level decreased to below 90% every shift. RN 2 stated she could not find documentation when O2 was increased to 5LPM or what the cause was and if the physician was notified. RN2 further stated there was no care plan addressing O2 therapy in Resident 6's records, that O2 levels cannot be changed without physician's orders. During a concurrent interview and record review on 1/2/2025 at 8:05 AM, RN 2 stated it was important for humidifiers to be labeled with resident's name and date so staff would know when to change the humidifier and tubing. During a review of the facility's P&P titled, Oxygen Therapy, revised 1/2024, the P&P indicated that oxygen therapy is administered, as ordered by the physician or as an emergency measure until the order can be obtained. The P&P also indicated to label the humidifier with resident name and date.

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F 0825 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or get specialized rehabilitative services as required for a resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46087 Based on interview, and record review, the facility failed to provide Occupational Therapy (OT, improving the patient's ability to perform activities of daily living) and Physical therapy (PT, treatment that helps you improve how your body performs physical movements) for one (1) of two (2) sampled residents (Resident 2) as indicated on the Physician's order, care plan, and facility assessment tool. This deficient practice placed Resident 2 at risk for decline in physical functions and developing contractures (condition of shortening and hardening of muscles, tendons, or other tissue, often leading to deformity and rigidity of joints), which could negatively affect the resident's overall wellbeing. Findings: During a review of Resident 2's Admission Record, the Admission Record indicated the facility admitted Resident 2 on 11/7/2024. Resident 2's diagnoses included muscle weakness, gastrostomy a surgical opening fitted with a device to allow feedings to be administered directly to the stomach common for people with swallowing problems) and end stage renal disease (ESRD-irreversible kidney failure). During a review of Resident 2's Minimum Data Set (MDS - a resident assessment tool), dated 11/20/2024, the MDS indicated Resident 2 was moderately impaired (decisions poor; cues/supervision required) with cognitive (processes of thinking and reasoning) skills for daily decision making. The MDS indicated Resident 2 required supervision (helper provides verbal cues) with oral hygiene. The MDS indicated Resident 2 required partial/moderate assistance (helper does less than half the effort) with upper body dressing and personal hygiene. The MDS indicated Resident 2 required substantial/maximal assistance (helper does more than half the effort) with toileting hygiene, shower/bathe self and lower body dressing. The MDS indicated Resident 2 was dependent (helper does all the effort) with eating [NAME] putting on/taking off footwear. The MDS indicated Resident 2 has no functional limitation in range of motion on upper extremity (shoulder, elbow, write, hand) and lower extremity (hip, knee, ankle, foot). The MDS indicated Occupational therapy start date of 11/8/2024 with zero (0) minutes. The MDS indicated Physical therapy start date of 11/8/2024 with zero (0) minutes. During a review of Resident 2's care plan initiated on 11/7/2024 and revised on 12/27/2024, the care plan indicated Resident 2 is at risk for further decline in Activities of Daily Living (ADLs- activities such as bathing, dressing and toileting a person performs daily). The facility interventions were the following: Assist in transfer Encourage to continue participating in performing activities of daily living (ADLs) within his capability including but not limited to washing face, combing hair, feeding self, raising arm during care, dressing and bathing. Follow Occupational Therapy (OT, improving the patient's ability to perform activities of daily living) recommendations. (continued on next page)

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	555213	A. Building B. Wing	01/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pasadena Care Center, LLC	1640 N. Fair Oaks Avenue Pasadena, CA 91103

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F 0825 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 2's Rehabilitation (Rehab) Screening Form, dated 12/2/2024, the Rehab Screening form indicated the Director of Rehab (DOR) had reviewed Resident 2's chart and due to the resident's medical diagnosis or condition, resident may require rehab intervention. The form indicated Resident 2 has left side upper and lower extremities impairment. During a review of Resident 2's Order Summary Report, dated 1/2/2025, timed 12:44 PM, the Order Summary Report indicated an order for Physical therapy (PT, treatment that helps you improve how your body performs physical movements) and OT evaluation and treatment if indicated pending authorization. During a review of Resident 2's insurance request form for pre-service review dated 12/8/2024, the form indicated a request for service from 12/9/2024 to 1/10/2025. The form also indicated treatment provided by referring physician (Doctor) that includes requesting skilled (medical and nursing services provided by licensed healthcare professionals, such as nurses, therapists, and doctors, to individuals who require ongoing medical attention and assistance with daily activities) level for PT/OT/Speech Therapy (ST, training to help people with speech and language problems to speak more clearly) services. During a concurrent interview and record review on 1/2/2025 at 7:41 AM with Registered Nurse 1 (RN 1), Resident 2's Electronic medical records for active orders were reviewed. The active orders indicated an order of PT and OT evaluation and treatment if indicated pending authorization, with order date of 12/5/2024. RN 1 stated Resident 2 did not receive PT/OT because the authorization from insurance was pending. During an interview on 1/2/2025 at 9:36 AM with DOR, the DOR stated Resident 2 had been in and out of the facility. The DOR stated Resident 2 was readmitted back to the facility on [DATE] and Rehab screening was done on 12/2/2024 indicating Resident 2's need for PT and OT because Resident 2 was assessed to be weaker than before. The DOR stated while waiting for insurance authorization, Resident 2 was placed on RNA. The DOR stated Business Office Manager (BOM) manages the insurance authorization and notifies the Rehab department once the insurance approves the authorization for Rehab department to provide PT/OT to the residents. The DOR stated the importance for residents to receive PT/OT services were to minimize a decline of range of motion, ambulation, promote the highest level of functioning, and prevent contractures and any further decline. During an interview on 1/3/2025 at 11:54 AM with BOM, she stated the insurance authorization request for Resident 2's PT and OT services was submitted on 12/8/2024. BOM stated as of today (1/3/2025), the insurance have not responded, therefore she has not communicated to DOR that PT and OT services can be provided to Resident 2. DOR stated that with cases of insurance denial of service, the Facility's Administrator (ADMIN) will be notified. BOM added the ADMIN makes the decision if the resident will be provided PT/OT service for free of charge. BOM stated on 12/17/2024, she followed up the insurance authorization request and the status was still pending. During an interview on 1/3/2025 at 12:50 PM with MDS nurse (MDSN), MDSN stated Resident 2 was readmitted to the facility on [DATE] and has an order for PT/OT evaluation and treatment if indicated (pending authorization) on 12/3/2024. MDSN verified Resident 2 did not receive PT/OT services since 11/29/2024. MDSN stated contractures and decline can be prevented by providing PT services to the residents. MDSN stated PT/OT services should have been provided to Resident 2 per physician's order. (continued on next page)

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F 0825 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Facility Assessment tool, dated 12/19/2024, indicated services the facility provides include the following: Physical Therapy Occupational Therapy Speech Therapy Long-Term care Skilled Care During a concurrent interview and record review on 1/3/2025 at 12:13 AM with ADMIN, the Facility Assessment tool, dated 12/19/2024 was reviewed. The Facility assessment tool indicated PT, OT and speech are services and care offer based on residents' needs. The ADMIN stated that Facility Assessment tool did not indicate that PT, OT, ST services should be given to residents after insurance authorization or payment verification. The ADMIN stated she did not know what happened to Resident 2's insurance authorization. The ADMIN stated that she did not have a knowledge of Resident 2 not being provided with PT and OT services because of pending insurance authorization. ADMIN added PT and OT should have been provided because it was in the order.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. 46087 Based on interview and record review, the facility failed to maintain an accurate resident medical records for one of two sampled Residents (Resident 1) by failing to ensure vital signs (measurements of the body's most basic functions that include body temperature, blood pressure, pulse rate, breaths per minute, and the amount of oxygen circulating in blood, also known as oxygen saturation [level of oxygen in the blood]) were not documented on 12/22/2024, 12/23/2024, 12/24/2024 and 12/25/2024 while Resident 1 was in the General Acute Hospital (GACH, a health facility having a duly constituted governing body with overall administrative and professional responsibility and an organized medical staff that provides 24-hour inpatient care.) This deficient practice had the potential for staff to not know the resident's actual condition resulting to necessary services and care not provided to the resident. Findings: During a review of Resident 1's Admission Record, the Admission Record indicated the facility admitted Resident 1 on 9/30/2021. Resident 1's diagnoses included epilepsy (happens as a result of abnormal electrical brain activity, kind of like an electrical storm inside your head), human immunodeficiency virus (HIV, is a virus that attacks the body's immune system), 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 1's Minimum Data Set (MDS - a resident assessment tool), dated 11/26/2024, the MDS indicated Resident 1 was severely impaired with cognitive (processes of thinking and reasoning) skills for daily decision making. The MDS indicated Resident 1 was dependent (helper does all the effort) with eating, oral hygiene, toileting hygiene, shower / bathe self, upper body dressing, lower body dressing and putting on/taking off footwear and personal hygiene. During a review of a facility form titled, SBAR (Situation, Background, Assessment, Recommendation, a communication tool used by healthcare workers when there is a change of condition among the residents) Communication Form and Progress Notes, dated 12/20/2024, timed at 11:14 PM, the form indicated Resident 1 was transferred to hospital via 911 (emergency telephone number) due to tachycardia (a heart rate that's faster than normal). During a review of Facility's census (a count of the number of people receiving care at a facility at a given time), dated 12/21/2024, the census indicated Resident 1 was on bed hold (a resident's right to keep a bed vacant and available for seven days after their transfer to the hospital in anticipation of their return to the facility). During a review of Facility's Census, dated 12/22/2024, 12/23/2024, 12/24/2024, and 12/25/2024, the census indicated Resident 1 was on bed hold. During a review of Resident 1's weights and vitals summary, dated 1/3/2025, the following dates and vital signs were recorded by Registered Nurse 1 (RN 1): (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 12/22/2024, timed 12:27 AM, blood pressure (a measurement that tells how hard the heart is pumping to move blood) of 126/70. On 12/22/2024, timed 12:30 AM, temperature of 97.6 Fahrenheit (F, unit of measurement) On 12/22/2024, timed 12:33 AM, respiration (the act of breathing) of 19 breaths per minute. On 12/22/2024, timed 12:31 AM, pulse rate (a measurement of how many times the heart beats in a minute) of 76 beats per minute. On 12/22/2024, timed 12:34 AM, oxygen saturation (a measurement of how much oxygen is in your blood) rate of 97 percent (%), room air (the air we breathe in everyday environments). On 12/23/2024, timed 1:29 AM, blood pressure of 123/69. On 12/23/2024, timed 1:30 AM, temperature of 97.9 F On 12/23/2024, timed 1:34 AM, respiration of 18 breaths per minute. On 12/23/2024, timed 1:31 AM, pulse rate of 71 beats per minute. On 12/23/2024, timed 1:35 AM, oxygen saturation rate of 98 %, room air. On 12/24/2024, timed 1:50 AM, blood pressure of 102/75. On 12/24/2024, timed 2:26 AM, respiration of 18 breaths per minute. On 12/24/2024, timed 2:24 AM, pulse rate of 71 beats per minute. On 12/24/2024, timed 2:28 AM, oxygen saturation rate of 97 %, room air. On 12/25/2024, timed 2:11 AM, blood pressure of 125/70. On 12/25/2024, timed 2:13 AM, temperature of 97.6 F On 12/25/2024, timed 2:15 AM, respiration of 19 breaths per minute. On 12/25/2024, timed 2:14 AM, pulse rate of 76 beats per minute. On 12/25/2024, timed 2:17 AM, oxygen saturation rate of 97 %, room air. During a concurrent interview and record review on 1/3/2025 at 7:03 AM with RN 1, Resident 1's vital signs were reviewed. RN 1 stated that she was made aware on 12/20/2024 night that Resident 1 was transferred to the hospital due to change of condition. RN 1 stated the vital signs documented for Resident 1 on 12/22/2024, 12/23/2024, 12/24/2024, and 12/25/2024 were inaccurate because Resident 1 was in GACH during this time. RN 1 stated documenting vital signs should be after each assessment for accuracy of documentation and to avoid having mistakes. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of RN 1's written statement, dated 1/3/2025, the written statement indicated, For Resident (Resident 1)'s vital signs on 12/22/2024 to 12/25/2024, I admitted that those numbers are made up. During a concurrent interview and record review on 1/3/2025 at 12:45 PM with MDS nurse (MDSN), Resident 1's vitals signs were reviewed, MDSN stated there were vital signs documented for Resident 1 on 12/22/2024 to 12/25/2024 by RN 1 during the night shift (11 PM to 7 AM). MDSN stated that Resident 1 was not in the facility during those days. MDSN stated it is not an accurate documentation because Resident 1 was not in the facility from 12/22/2024 to 12/25/2024. MDSN stated, there should be no vital signs recorded for Resident 1 from 12/22/2024 to 12/25/2024. MDSN nurse stated wrong documentation can lead to wrong treatment and might cause harm to any residents. During a concurrent interview and record review on 1/3/2025 at 1:01 PM with RN 3, Resident 1's vital signs and discharge notes were reviewed. RN 3 stated Resident 1 was transferred to GACH on 12/20/2024 because of change of condition. RN 3 verified that there were vital signs documented for Resident 1 on 12/22/2024 to 12/25/2024 while Resident 1 was not in the facility. RN 3 stated it is not the facility's practice to document on the resident's records when the resident is not in the facility. RN 3 stated the vital signs documented on 12/22/2024 to 12/25/2024 were inaccurate because Resident 1 was not in the facility. RN 3 stated that vital signs are used by nurses and other staff for purpose of determining if some medications are to be given or not. RN 3 also stated, if vital signs are falsified, it could cause harm to the resident. RN 3 added vital signs are also used as part of the assessment process to ensure residents are stable. During a review of Facility's Policy and Procedure, titled Policy and Procedure on documentation, dated December 2024, policy indicated the facility to document tall pertinent data and information of each resident in their perspective medical record. Procedure indicated documentations should reflect all findings after assessment was done and reflect concern or problems of resident.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49537 Based on observation, interview and record review, the facility did not ensure staff followed the facility's isolation (separation of residents with an infection from residents without an infection) and enhanced barrier precautions (EBP- refers to an infection control intervention designed to reduce transmission of multidrug-resistant organisms [MDROs] that employs targeted gown and glove use during high contact resident care activities) policies for two of two sampled residents (Residents 4 and 7) and four of eight rooms (Rooms 3, 7, 9, and 11) with residents on EBP by: 1. Resident 4 did not have isolation signage posted outside the room door or wall. 2. Staff did not wear personal protective equipment (PPE-equipment worn to minimize exposure to hazards that cause serious workplace injuries and illnesses. PPEs may include gloves, safety glasses and shoes, gowns, or coveralls) when providing care to Resident 7 who has a gastrostomy (a surgical opening fitted with a device to allow feedings, fluids, and medications to be administered directly to the stomach common for people with swallowing problems) tube. 3. PPE carts were not located outside Rooms 3, 7, 9, and 11 with residents on EBP. These deficient practices had the potential to result in residents developing an infection and spread infection among staff and other residents. Findings: 1. During a review of Resident 4's Admission Record, the Admission Record indicated the facility initially admitted the resident on 9/2/2024 and was readmitted on [DATE] with diagnoses that included, but not limited to end stage renal disease (ESRD-irreversible kidney failure) requiring hemodialysis (a treatment to cleanse the blood of wastes and extra fluids artificially through a machine when the kidneys have failed), type II diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing), congestive heart failure (CHF-a heart disorder which causes the heart to not pump the blood efficiently, sometimes resulting in leg swelling), sleep apnea (a sleep disorder characterized by pauses in breathing during sleep), dependence on supplemental oxygen therapy (a treatment that provides extra oxygen to people who have breathing problems or low oxygen levels in their blood) and methicillin resistant staphylococcus aureus blood stream infection (MRSA bacteremia-a severe infection that occurs when MRSA is present in the blood and a bacteria that does not respond to antibiotics). (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 4's Minimum Data Set (MDS-a resident assessment tool), dated 12/16/2024, the MDS indicated Resident 4 had moderate impairment with cognitive (mental processes that take place in the brain, including thinking, attention, language learning, memory, and perception skills for daily decision making) skills for daily decision making. The MDS also indicated Resident 4 required partial/moderate assistance (Helper lifts, holds, or supports trunk or limbs but provides less than half the effort) with eating. MDS also indicated resident required substantial/maximal assistance (Helper lifts or holds trunk or limbs and provides more than half the effort) with oral, personal hygiene and upper body dressing. The MDS further indicated the resident was dependent (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 toileting hygiene, showering/bathing self, lower body dressing and putting on/taking off footwear. During a review of Resident 4's Physician's order, the order contact isolation (a set of precautions used to prevent the spread of infectious diseases caused by bacteria and viruses) for MRSA of the blood. During an observation on 1/2/2025 at 5:40 AM outside Resident 4's door, there was no isolation or EBP signage posted. 2. During a review of Resident 7's Admission Record, the Admission Record indicated the facility initially admitted the resident on 2/6/2024 and was readmitted on [DATE] with diagnoses that included, but not limited to hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body) and hemiparesis (one sided muscle weakness) following cerebral infarction (also known as an ischemic stroke, is a serious condition that occurs when blood flow to the brain is blocked) affecting the right dominant side, dysphagia (difficulty swallowing), GT status, protein calorie malnutrition (a nutritional status in which reduced availability of nutrients leads to changes in body composition ad function), paraplegia (loss of movement and/or sensation, to some degree, of the legs), and dementia (a progressive state of decline in mental abilities). During a review of Resident 7's History and Physical (H&P), dated 2/7/2024, the H&P indicated the resident had fluctuating capacity to understand and make decisions. During a review of Resident 7's MDS dated [DATE], the MDS indicated Resident 7 required substantial/maximal assistance (Helper lifts or holds trunk or limbs and provides more than half the effort) with upper body dressing and personal hygiene. The MDS also indicated Resident 7 was dependent with eating, oral/toileting hygiene, showering/bathing self, lower body dressing and putting on/taking off footwear. During an interview at 1/2/2025 at 6:56 AM, Certified Nurse Assistant 1 (CNA 1), CNA1 stated she only wore gloves since 11 PM last night when she changed Resident 7. CNA1 stated there was no cart with gowns outside Resident 7's door. CNA 1 also stated germs (refers to microscopic bacteria, viruses, fungi, and protozoa that can cause disease) can be spread from resident to resident if staff do not wear gloves and gown. During a phone interview on 1/2/2025 at 1:23 PM with Registered Nurse 1 (RN 1), RN 1 verified that when she checked Resident 7's GT placement and flushed his GT with water at 12 AM and 6 AM on 1/2/2025, she was not and should have worn a gown. RN 1 stated there was no PPE cart, no gowns ready for use by Resident 7's door. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. During an observation on 1/2/2025 at 5:43 AM, Rooms 3, 7, 9, and 11 were observed with EBP signage by their respective doors but there were no PPE carts. During a concurrent observation and interview on 1/2/2025 at 5:47 AM outside room [ROOM NUMBER] and room [ROOM NUMBER], with RN 1, RN 1 verified that there was an EBP signage outside rooms [ROOM NUMBERS] but there were no PPE carts for immediate use. RN 1 stated room [ROOM NUMBER]B's resident has a GT so resident is on EBP. RN 1 further stated that if staff had no PPE to use during resident care, there was potential for germs to spread from resident to resident via staff. During a concurrent observation and interview on 1/2/2025 at 6:32 AM outside room [ROOM NUMBER], with CNA 2, CNA 2 was observed entering room [ROOM NUMBER] carrying linens. CNA 2 was not wearing gloves and did not wear a gown. CNA 2 stated she saw the EBP signage but there was no PPE cart with gowns since she started her shift at 11 PM last night. During a concurrent observation and interview on 1/3/2025 at 12:35 PM, IPN stated she was aware that the staff working on 11 PM to 7 AM shift on 1/2/2025 did not use gowns while caring for EBP residents as there were no gowns available outside the rooms. IPN further stated it was not acceptable that gowns were not worn during care of EBP residents as infection control was not followed. During a review of the undated EBP P&P, the P&P indicated EBPs are utilized to prevent the spread of multi-drug resistant organisms (MDROs) to residents. EBPs employ targeted gown and glove use during high contact resident care activities when contact precautions do not otherwise apply. Examples of high contact resident care activities requiring the use of gown and gloves for EBPs include but not limited to: a. Dressing b. Providing hygiene c. Changing linens d. Changing briefs or assisting with toileting e. Device care or use (central line, urinary catheter, feeding tube) The P&P also indicated that signs are posted in the door or wall outside the resident room indicating the type of precautions and PPE required. PPE is available outside the resident rooms. During a review of the Isolation P&P, the P&P indicated when the resident is placed on transmission-based precautions, appropriate notification is placed on the room entrance door and on the front of the chart so that personnel and visitors are aware of the need for and the type of precaution. The signage informs the staff of the type of Centers for Disease Control and Prevention (CDC) precautions, instructions for use of PPE, and/or instructions to see a nurse before entering the room.