| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | **055548** | A. BUILDING _____ B. WING _____ | **07/14/2020** |

| NAME OF PROVIDER OF SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP |
|---|---|
| **PASADENA PARK HEALTHCARE AND WELLNESS CENTER** | **2585 E. WASHINGTON BLVD. PASADENA, CA 91107** |

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 0689<br><br>**Level of harm -** Minimal harm or potential for actual harm<br><br>**Residents Affected -** Some | **Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Based on observation and interview, the facility failed to ensure residents remained free from accident hazards. The facility failed to ensure chemicals were stored in a secure area. * Four spray bottles containing Clorox (bleach) were left on a table in Station A for any unauthorized person to access to, including confused residents. This failure increased the risk of residents to access this toxic and hazardous chemical. Findings: Review of the Clorox Disinfecting Bleach Safety Data Sheet revised 1/4/19, showed the product is considered hazardous and causes severe [MEDICAL CONDITION] eye damage. Under section for Handling and Storage, it identified this chemical should be stored in a locked or secure manner. On 7/7/2020 at 0818 and 0835 hours, four spray bottles labeled as Clorox 1:9 were observed sitting on top of a table in front of Station A. The Clorox bottles were left unattended and unsecured and there was no staff observed in Station A. On 7/7/2020 at 0845 hours, a resident was observed walking by the unsecured Clorox spray bottles. On 7/7/2020 at 0900 hours, an interview was conducted with the Activities Director. When asked what the Clorox bottles were for, the Activities Director stated it was for staff to clean or disinfect common surface areas. When asked if residents ambulated on the unit, the Activities Director stated yes, there were some who were independent to do so. The Activity Director was asked how the staff ensured the safety of the residents when the Clorox spray bottles were left unattended and accessible to anyone, including confused residents. The Activities Director stated she would have to discuss the concern with administration. On 7/7/2020 at 1014 hours, an interview was conducted with the Administrator. The Administrator stated he was aware chemicals such as Clorox needed to be locked away from unauthorized access. |
| F 0695<br><br>**Level of harm -** Minimal harm or potential for actual harm<br><br>**Residents Affected -** Few | **Provide safe and appropriate respiratory care for a resident when needed.**<br><br>Based on observation, interview, and facility P&P review, the facility failed to ensure a non-rebreather mask (a single resident use mask to deliver oxygen) was dated or labeled or stored in a plastic bag. This failure had the potential to increase the risk for bacterial contamination of the oxygen equipment, increasing the risk for a resident infection. Findings: Review of the facility's P&P titled Oxygen Therapy revised 11/17, showed the staff are to ensure the safe storage and administration of oxygen to residents. On 7/7/2020 at 0948 hours, an isolation cart was observed outside of Room A. Inspection of the isolation cart identified an unlabeled non-rebreather oxygen mask in the top drawer. New rebreather masks are delivered in plastic bags to ensure their integrity and prevent from being soiled and cause potential infection to the user. This mask was not in a bag or labeled it identify when it was opened and provided to the resident inside Room A. On 7/7/2020 at 1001 hours, an observation and concurrent interview was conducted with the Director of Staff Development (DSD). The DSD verified the the non-rebreather mask was not in a bag or labeled. The DSD stated the non-rebreather mask should be labeled and stored in a plastic bag. The DSD stated there was no way to know if the non-rebreather mask had been used or not. |

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

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.