STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555894	A. Building B. Wing	12/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Foothill Heights Care Center	1515 North Fair Oaks Ave 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 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. (continued on next page)

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

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

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F 0842 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 interviews and record review, the facility failed to maintain accurate documentation of wound care treatments for one (1) of two (2) sampled residents (Resident 1) on the resident's Treatment Administration Record (TAR) in accordance with the facility's policy. This deficient practice had the potential to result in miscommunication among staff and resulted in inaccurate representation of care provided to Resident 1. Findings: During a review of Resident 1's admission Record, the admission Record indicated the resident was initially admitted to the facility on [DATE] and was readmitted on [DATE] with diagnoses that included muscle contracture (a stiffening/shortening at any joint, that reduces the joint's range of motion) of the left and right lower leg. During a review of Resident 1's Care Plan revised on 9/11/2025, the Care Plan indicated Resident 1 had wounds on the base and shaft of the fifth (5th) metatarsal (long bone on the outer edge of the foot that connects to the smallest toe) and on the left great toe with an intervention that included treatment as ordered. During a review of Resident 1's Minimum Data Set (MDS- a resident assessment tool), dated 11/20/2025, the MDS indicated Resident 1 had severe impairment in cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decision making. The MDS also indicated Resident 1 was dependent (helper does all the effort) with eating, oral, toileting, and personal hygiene, shower, upper/lower body dressing and putting on/taking off footwear. During a review of Resident 1's physician's order dated 11/21/2025 timed at 1:45 PM, the physicians order indicated to perform daily dressing changes to Resident 1's left great toe which included cleansing the wounds with normal saline (NS-a saltwater solution), pat dry, paint the peri wound with Betadine solution (an antiseptic used to kill germs and prevent infection particularly on the skin), apply Medi Honey (a medical- grade honey dressing that can be used to treat a variety of wounds), cover with collagen alginate (a light, nonwoven fabrics derived from algae or seaweed), then abdominal pad, and wrap with gauze bandage roll. During a review of Resident 1's physician's order dated 11/21/2025 timed at 2 PM, the physicians order indicated daily dressing changes to Resident 1's left 5th metatarsal head to shaft which included cleansing the wounds with NS, pat dry, paint peri wound with betadine, apply Medi Honey, cover with collagen alginate, then abdominal pad, and wrap with gauze bandage roll. During a concurrent interview and review with the Treatment Nurse (TN) on 12/10/2025 at 1 PM, the TAR for the month of November was reviewed. TN stated there were missing wound treatments for 11/22/2025 and 11/24/2025 which included cleansing the wounds with NS, pat dry, paint peri wound with betadine, apply Medi Honey, cover with collagen alginate, then abdominal pad, and wrap with gauze bandage roll on the following sites:a) Left head metatarsal head to shaft.b) Left great toe. During an interview on 12/10/2025 at 1:13 PM, the TN stated he remembered providing the wound treatments but forgot to document them in the TAR. The TN also stated wound treatments should be documented and signed to indicate it was provided and would not look like it was not done. The TN also stated the TAR should be signed off by the TNs after the wound care treatment was provided. During an interview on 12/10/2025 at 1:47 PM, the Director of Nursing (DON) stated Resident 1's wound treatment should be accurately documented so we can confirm the resident's wound treatment was provided. During an interview on 12/10/2025 at 4:15 PM, the Administrator (ADM) stated that wound care treatment should be accurately documented to ensure wound treatments were provided as ordered. During a review of the facility's undated policy and procedure (P&P) titled, Charting and Documentation, revised 7/2017, the policy indicated that all services provided to the resident, .shall be documented in the resident's medical record. The policy also indicated that documentation in the medical record will be objective (not opinionated or speculative), complete, and accurate. The policy further indicated that documentation of the procedures and treatments will include care -specific detail, including date and time the procedure/treatment was provided, name and title of the individual (s) who provided the care, and the signature and title of the individual documenting.