STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055480	A. Building B. Wing	08/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Californian Pasadena Healthcare	120 Bellefontaine Street Pasadena, CA 91105

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 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. (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
	055480	A. Building B. Wing	08/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Californian Pasadena Healthcare	120 Bellefontaine Street Pasadena, CA 91105

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 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** S483.25(d) Accidents. The facility must ensure that - S483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and S483.25(d)(2) Each resident receives adequate supervision and assistance devices to prevent accidents. Based on interview and record review, the facility failed to provide adequate supervision for one of four sampled residents (Resident 1) who was assessed as high risk for falls by failing to develop a comprehensive resident-centered care plan (a care plan developed and implemented to meet his or her preferences and goals, and addressed the resident's medical, physical, mental, and psychosocial needs) after Resident 1's fall on 8/10/2025. This deficient practice resulted in Resident 1's repeated fall on 8/12/2025 at 6:19 PM. Findings: During a review of Resident 1's admission Record, the admission Record indicated Resident 1 was initially admitted on [DATE] and was readmitted on [DATE] with diagnoses that included non-traumatic intracerebral hemorrhage (the bleeding into the brain tissue that occurs without a physical injury or trauma), ataxia (a condition characterized by a lack of coordination and balance), and muscle weakness. During a review of Resident 1's Minimum Data Set (MDS - a resident assessment tool), dated 8/6/2025, the MDS indicated Resident 1 was assessed having severely impaired cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decision making. Resident 1 required substantial/maximal assistance (helper does more than half the effort, helper lifts or holds the trunk or limbs and provides more than half the effort) with toileting hygiene, shower/bathe self, lower body dressing, and putting on/taking off footwear. Resident 1 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 sit to lying, sit to stand, chair/bed-to-chair transfer, and walking 10 feet (ft- unit of measurement). During a review of Resident 1's Fall Risk Assessment, dated 8/10/2025, the Fall Risk Assessment indicated a score of 12 (a score of 10 or above represents high risk for falls). During a review of Resident 1's Progress Notes, dated 8/10/2025, timed at 2:30 PM, the Progress Notes indicated Resident was found sitting on the floor mat at the left (L) side of her bed. When asked the resident what happened, resident was not able to describe what happened. During a review of Resident 1's Interdisciplinary Team (IDT- a meeting where healthcare professionals from different disciplines collaborate to develop or review a resident's care plan) Progress Note, dated 8/11/2025, the IDT Progress Note indicated Resident 1 was found sitting on the floor on the left side of her bed. The IDT Recommendation indicated, Resident 1 remains at risk for falls due to impaired safety awareness. Education provided and reinforced regarding use of call light. Plan of care to continue with fall precautions and ongoing monitoring. During a review of Resident 1's Situation-Background-Assessment-Recommendation (SBAR- a document that provides a framework for communication between members of the health care team about a resident's condition), dated 8/12/2025, the SBAR indicated that on 8/12/2025, at 6:19 PM, an unknown resident's Responsible Party 1 (RP 1) saw Resident 1 trying to reposition self from her wheelchair and got up. Licensed Vocational Nurse 1 (LVN 1) stated heard a sound and got up and saw the Resident on the floor before he could catch her. SBAR indicated, per LVN, Resident 1 fell forward on the floor on her left side. Resident 1 was unresponsive to verbal and physical stimuli and loudly snoring as she was asleep. During a review of Resident 1's Progress Notes, dated 8/12/2025, timed at 6:37PM, the Progress notes indicated at 5:45PM, after dinner, Resident 1, while on the wheelchair was placed in front of the nurses' station with other residents. At 6:15PM, Resident 1 was in a wheelchair in front of the nurses' station while LVN (not specified) was passing medications. At 6:19PM, RP 1 saw Resident 1 trying to reposition self from the wheelchair and got up. The LVN (LVN 1) at the nurse's station heard the sound and got up but Resident 1 was already on the floor before LVN 1 could catch her. During an interview, on 8/27/2025, at 1:45 PM, with LVN 1, LVN 1 stated CNA 1 placed Resident 1 in the hallway across from Nurse's Station after dinner. LVN 1 stated Resident 1 was not confused but was not moving around in her wheelchair when CNA 1 left her by the hallway. LVN 1 stated he was not familiar with Resident 1's care but knew that she was in the Falling Star Program (a program that serves as a visual identifier and reminder system for staff to recognize residents who are determined to be at risk for falls). LVN 1 stated he did not know that Resident 1 had a history of falls or what type of supervision Resident 1 needed. LVN 1 stated he was inside the Nurse's Station assisting another family member with lab results when he saw Resident 1 try to get up from her wheelchair. LVN 1 stated he attempted to assist Resident 1 but by the time he got to Resident 1 she already fell on the floor. LVN 1 stated he saw Resident 1 fall face down and