

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 10/09/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055480	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/31/2026
NAME OF PROVIDER OR SUPPLIER The Californian Pasadena Healthcare		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **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 two (2) of three (3) sampled residents (Resident 3 and 4) in accordance with the facility's policy and procedure (P&P) when: On 7/30/2026 and 7/31/2026, facility staff did not ensure Resident 3's lunch meal tray was served within the facility's scheduled mealtimes. 2. On 7/30/2026, Licensed Vocational Nurse 1 (LVN 1) did not ensure Resident 4 was given medication in a private room such as the resident's room and not in the dining room while wearing gloves. These deficient practices have the potential to affect Residents 3 and 4 sense of self-worth and self-esteem, which could negatively impact the residents' emotional and mental well-being. Findings: 1. During a review of Resident 3's admission Record, the admission Record indicated Resident 3 was admitted to the facility on [DATE], with diagnoses that included dementia (a progressive state of decline in mental abilities), major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest), and anxiety (a feeling of worry, fear, or uneasiness about what might happen). During a review of Resident 3's Minimum Data Set (MDS, a resident assessment tool), dated 7/18/2026, the MDS indicated Resident 3 had moderately impaired (decisions poor; cues/supervision required) cognitive skills (mental action or process of acquiring knowledge and understanding) for daily decision making. The MDS indicated Resident 3 required supervision (helper provides verbal cues) with eating, oral hygiene, upper body dressing and personal hygiene. The MDS indicated Resident 3 required substantial/maximal assistance (helper does more than half the effort) with toileting hygiene, shower/ bathe self, lower body dressing, and putting on/ taking off footwear. During a concurrent observation and interview with Treatment Nurse (TN) on 7/30/2026 at 12:14 PM in the dining room, Resident 3 was observed sitting on her wheelchair with 4 other residents in the dining table. Resident 3's lunch tray was not on the table, and the other 4 residents were eating their lunch. TN verified Resident 3 has no lunch tray yet, and Resident 3 is watching the other 4 residents eating, and the other resident (Resident 5) already finished eating the lunch meal as evidenced by empty plate in front of Resident 5. TN stated he did not know why Resident 3's lunch tray was not included in the trays delivered with the other 4 residents' in the dining room. During an interview on 7/30/2026 at 4:28 PM with Assistant Director of Nursing (ADON), she stated Resident 3 was not served lunch meal on time which should have been between 12 noon to 12:15 PM with other residents in the dining room. ADON stated Resident 3's lunch meal tray was late, and Resident 3 would feel left out and upset. During an observation on 7/31/2026 at 12:15 PM in the dining room, Resident 3 was sitting in her wheelchair, seated on the dining table with 3 other residents. Resident 3 was observed with no lunch tray, and the other 3 residents are eating their lunch. During an interview on 7/31/2026 at 1:46 with the Director of Nursing (DON), the DON explained that delays can cause residents to feel hungry (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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:	Facility ID: 055480 If continuation sheet Page 1 of 7

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure one (1) of two sampled residents (Resident 2) environment was free from accident hazard when a medicine cup of potassium (electrolyte supplements used to treat or prevent low blood potassium (hypokalemia) was left at Resident 2's bedside and failed to assess Resident 1's ability to self-administer medications. This failure had the potential to result in other residents inadvertently ingesting medication intended for Resident 2. Findings: During a review of Resident 2's admission Record, it was noted that the resident was initially admitted to the facility on [DATE] with diagnoses of muscle weakness, hypertension (high blood pressure), and depression (severe feelings of sadness and hopelessness). During a review of Resident 2's Minimum Data Set (MDS-a resident assessment tool), dated 6/11/2026, the MDS indicated that the resident had moderately impaired cognitive skills for daily decision-making. The MDS indicated Resident 2 needed partial to moderate assistance (helper does less than half the effort) with eating, oral hygiene, and personal hygiene (the ability to maintain personal hygiene, including combing hair, shaving, applying makeup, and washing and drying face and hands). During an observation on 7/30/2026 at 10:28AM, in Resident 2's room, on Resident 2's bedside table there was an unattended medicine cup full of a bright orange liquid that had not been consumed. During a concurrent observation and interview on 7/30/2026 at 10:28 AM, with Licensed Vocational Nurse (LVN) 1, in Resident 2's room, the unattended medicine cup full of bright orange liquid was observed. LVN 1 stated the medication on the table is Resident 2' potassium. LVN 1 stated Resident 2 told LVN 1 that the resident wanted to take the medication at a later time. LVN 1 stated the importance of seeing the patient take all of the resident's medication, was to ensure Resident 2 will not have any health concerns. During a concurrent interview and record review on 7/30/2026 at 1:01 PM, with LVN 2, Resident 2's Order Summary for Active orders, dated 6/5/2026 to 7/30/2026 was reviewed. The Order Summary indicated Resident 2 had no orders for self-medication administration. During a concurrent interview and record review on 7/30/2026 at 1:05 PM, with LVN 2, Residents 2's Admission/readmission Initial Assessment dated 06/06/26 was reviewed. The Admission/readmission Initial Assessment indicated that the resident did not have authorization to self-administer medication. LVN 2 stated Resident 2's having medication left unattended without a nurse at the bedside was an issue because Resident 2's initial assessment indicated the resident was unable to safely self-administer medications. LVN 2 stated, LVN 1 should have watched Resident 2 take all of the resident's medications, to ensure that other residents would not have the opportunity to access or potentially take Resident 2's medications. During a concurrent interview and record review on 7/30/26 at 2:16 PM with Assistant Director of Nursing (ADON), Resident 2's Admission/readmission Initial Assessment, dated 06/06/26 and Care Plan for month of June 2026 and July 2026 were reviewed. The Admission/readmission Initial Assessment and Care Plan indicated, Resident 1 was not approved for self-administration and should have been directly monitored by nursing staff for the entire medication administration. ADON stated, nurses must stay with the resident and watch the resident finish the medications during medication administration unless the resident can self-administer so resident is not at risk for safety issues such as a resident ingesting the wrong medication. ADON stated Resident 2 did not have anything in the resident's care plan or assessments indicating medication self-administration was authorized. During a review of the facility's policy and procedure titled, Safety and Supervision of Residents, revised February 2021, it (continued on next page)		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	indicated the facility strives to make the environment as free from accident hazards as possible. The policy also indicated the facility- oriented and resident- oriented approaches to safety are used together to implement a systems approach to safety, which considers the hazards identified in the environment and individual risk factors, and then adjust interventions accordingly. During a review of the facility's policy and procedure titled, Administering Medications, revised April 2025, indicated residents may self-administer their own medications only if the attending physician, in conjunction with the interdisciplinary care planning team, has determined that they have the decision-making capacity to do so safely.		

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. Based on interview and record review, the facility failed to ensure that the Restorative Nursing assistant (RNA , Certified Nursing Assistant [CNA] who has extra training to help patients recover lost physical skills, improve mobility, and maintain their independence) had current training and demonstrated competency in the proper use of a gait belt (assistive medical device worn around a person's waist to help caregivers safely support, stabilize, and transfer individuals with mobility or balance challenges) for resident transfers and / or ambulation. This deficient practice had the potential to place residents at risk for falls, injury, or unsafe transfer or ambulation. Findings: During a concurrent interview and record review on 7/31/2026 at 1:45 PM with the Infection Prevention Nurse (IPN), RNA's employee files were reviewed. IPN stated there was no current training and competency on gait belt found in the RNA's employee file. IPN explained the last gait belt training was dated 11/1/2021. IPN further stated gait belt training was supposed to be completed annually for resident's safety, so staff would know how to use the equipment properly and prevent possible accidents and harm to the residents. IPN also stated it was the Director of Staff Development's (DSD- manages, plans, and oversees education, training, and compliance programs for the nursing staff) responsibility to provide the gait belt training every year. During a concurrent interview and record review on 7/31/2026 at 3:18 PM with the Director of Nursing (DON), the facility's employee's job description titled Director of Staff Development, revised as of 10/2020 was reviewed. The DON stated according to the job description it was an essential function of the DSD to participate in the annual facility assessment by providing staff analysis, competency reports, and a gap analysis of training requirements and oversee and maintain personnel records. The DON stated, the DSD is also responsible for developing and maintaining written job description and performance evaluation for the CNA position. During a concurrent interview and record review on 7/31/2026 at 3:20 PM with the DON, the facility's Policy and Procedures (P&P) titled Professional Standards, revised on 1/2025, was reviewed. The DON stated that the purpose was to establish the requirement that all employees and contractors perform services in accordance with accepted professional standards of care, ensuring competence, safety, and regulatory compliance. The DON stated that the P&P was not followed; staff were supposed to be trained before using any equipment initially upon hire, annually, or as needed to decrease potential injury and ensure resident and staff safety and competency. During a concurrent interview and record review on 7/31/2026 at 3:34 PM with the Administrator (ADM), the Facility Assessment (an evaluation of the residents needs and staff resources required to provide proper care) dated 8/1/2025 and updated 7/31/2026 was reviewed. The ADM stated the facility assessment indicated, under Staff Training/Education and Competencies: The Director of Staff Development and/or designee are following strict guidelines and facility protocols in providing training and education to newly hired facility staff, current facility staff, and registry/contract staff, monitoring the training program's progress, and ongoing violation of the training. Skills competencies are completed yearly and as needed.		

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to accurately measure the Liquid Whole Eggs with Citric Acid (liquid whole eggs or egg whites in a carton) on 7/31/2026 for one (1) of one sampled resident who received eggs with veggies. This deficient practice had the potential to result in meal dissatisfaction, decreased nutritional intake, and weight loss for Resident 1 who received eggs with veggies. Findings: During a review of Resident 1 's admission Record, the admission Record indicated the resident was initially admitted to the facility on [DATE] with diagnoses of abnormalities of gait and a history of falling. During a review of Resident 1 's History and Physical Examination (H&P), dated 6/17/2026, the H&P indicated Resident 1 has the capacity to understand and make decisions. During a review of Resident 1's meal ticket (specifies a resident's exact diet order, portion sizes, allergies, and menu selections for staff to safely serve the correct food) dated 7/31/2026, the meal ticket indicated Resident 1 likes dry cereal and milk, and eggs with veggies. During observation on 7/31/2026 at 6:55 AM in the facility's kitchen, the Dietary [NAME] Helper (DCH 1) was observed pouring Liquid Whole Eggs with Citric Acid from the box onto the pan without measuring the liquid. During an interview on 7/31/2026 at 11:35 AM with Dietary Supervisor (DS), DS stated they are not supposed to estimate recipes, and ingredient must be measured using the appropriate measuring equipment to ensure the facility follows and provides proper nutrition to the resident and ensure palatability (how pleasant or acceptable a food, drink, or medicine tastes, or how easy it is to eat or drink) of the food for the resident. During a concurrent interview and record review on 7/31/2026 at 12:31 PM, with DCH 1 the handling instructions for Liquid Whole Eggs with Citric Acid undated was reviewed. DCH 1 stated the handling instruction indicated that for portion control, 1 large egg liquid is equivalent to three (3) tablespoons of the liquid. DCH 1 also stated he only poured the egg and did not measure it and acknowledged he should have measured the egg. During a concurrent interview and record review on 7/31/2026 at 3:40 PM with the Director of Nursing (DON), the facility's policy and procedure titled Menu, revised in 2021, was reviewed. The policy indicated menus meet the nutritional needs of residents in accordance with the recommended dietary allowances of the Food and Nutrition Board. The DON stated the policy indicated that menus are developed and prepared to meet residents' choices and needs. The DON also stated that the menus are supposed to be followed, and ingredients measured for therapeutic diets to ensure proper nutrition is given to residents.		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record review, the facility failed to ensure that food temperatures were checked and documented prior to serving breakfast when the temperature of the frittata and oatmeal were not checked on 07/31/2026. This deficient practice had the potential to place residents at risk for foodborne illness (any sickness caused by eating or drinking contaminated food or beverages) due to food not being maintained at safe temperatures. Findings: During an observation on 7/31/2026 at 7:02 AM at the facility kitchen during tray line (assembly line system used by the dietary department to efficiently build and prepare individual resident meal trays), observed [NAME] 1 serving the frittata without checking the temperature. During an observation on 7/31/2026 at 7:32 AM in the facility kitchen during tray line, Dietary Supervisor (DS) pulled out a tray with 12 bowls of oatmeal, and the temperature of the oatmeal was not checked prior to serving it to the residents. During an interview on 07/31/2026 at 11:35 AM with DS, DS stated she did not check the temperature of the oatmeal after taking it out of the oven. DS also stated, even though it was hot, she should have checked the temperature for residents' safety. During an interview on 07/31/2026 at 12:31 PM with [NAME] 1, [NAME] 1 stated he forgot to check the temperature of the frittata before serving it. [NAME] 1 also stated kitchen staff are supposed to check the food before they start serving the food to make sure it is at the correct temperature for resident's safety. During a review of the facility's Policy and Procedures (P&P) titled Food Preparation and Service, dated 2021, the P&P indicated the food and nutrition service employee prepares, distributes, and serves food in a manner that complies with safe food handling practices. It indicated proper hot and cold temperatures are maintained during distribution and service and foods that are held in the temperature danger zone are discarded after our (4) hours.		