STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055617	A. Building B. Wing	05/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pasadena Grove Health Center	1470 N 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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** 44636 Based on observation, interview, and record review, the facility failed to treat residents with respect and dignity and maintain privacy for one of two sampled residents (Resident 1). This deficient practice had the potential to negatively affect Resident 1's self-worth and psychosocial wellbeing. Findings: During a review of Resident 1's Admission Record, the Admission Record indicated Resident 1 was admitted to the facility on [DATE] with the diagnoses including but not limited to type 2 diabetes mellitus (a disease that occurs when there is a problem in the way the body regulates and uses sugar as fuel), end stage renal disease (advanced stage kidney failure) and hypertension (high blood pressure). During a record review of Resident 1's Minimum Data Set (MDS, a resident assessment and tool), dated 4/15/2025, the MDS indicated the resident's cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decision making was moderately impaired. The MDS indicated Resident 1 was dependent (helper does all the effort, resident does none of the effort to complete the activity) for toileting and shower/bathing self. The MDS also indicated Resident 1 required substantial/maximal assistance (helper does more than half the effort) for rolling left and right, sitting to lying, and lying to sitting on side of bed. During a record review of Resident 1's care plan, the care plan indicated Resident 1 stated male resident went into her room and touched her gown and leg. The care plan interventions for staff were to monitor resident for mood regarding male going into her room, keep resident safe and assign Certified Nurse Assistant (CNA) for 1:1 close monitoring. During a record review of Resident 1's SBAR (an acronym for Situation-Background-Assessment-Recommendation is a technique used to provide a framework for communication between members of the health care team), dated 5/10/2025, the SBAR indicated Resident 1 verbalized another resident went into her room and touched her leg and gown. (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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a record review of Resident 1's Nursing Note, dated 5/10/2025, the record indicated Resident 1 reported to CNA 1 that a male resident was in her room around 7:30 PM. CNA 1 pulled Resident 2 out of room and reported to charge nurse. During an interview on 5/13/2025 at 12:09 PM with Licensed Vocational Nurse 1 (LVN 1), LVN 1 stated CNA 1 reported that Resident 2 had gone into Resident 1's room around 7:30 PM. LVN 1 stated Resident 2 said he was looking for food. LVN 1 stated Resident 1 stated Resident 2 touched her leg and gown. During a concurrent observation and interview on 5/13/2025 at 12:30 PM with Resident 1 in Resident 1's room, Resident 1 stated Resident 1 was lying on her bed facing the wall when Resident 2 came in and started touching her right knee up to the midthigh. Resident 1 stated it made her feel really uncomfortable. Resident 1 stated she was not able to get up and feared Resident 2 would beat her up if she did something to Resident 2. During an interview on 5/13/2025 at 4:08 PM with Registered Nurse (RN), RN stated for the past week Resident 2 started going in front of other residents' rooms and was looking around their rooms. RN stated she needed to redirect and keep an eye on Resident 2. During an interview on 5/14/2025 at 4:35 PM with CNA 1, CNA 1 stated Resident 1 had her call light on and was screaming. CNA 1 stated when she entered Resident 1's room she saw Resident 2 touching the water and snacks on Resident 1's bedside table. CNA 1 stated Resident 1 told Resident 2 not to touch her stuff. CNA 1 stated Resident 2 tried to leave Resident 1's room with her snacks and CNA 1 had to tell Resident 2 to give them back. CNA 1 stated Resident 2 would go into other residents' rooms to take their stuff and eat their food. CNA 1 stated the residents were aware of his behavior and would tell Resident 2 not to go into their rooms. CNA 1 stated all the LVNs were also aware of Resident 2's behavior and always informed the CNAs Resident 2 needed to be checked on. CNA 1 stated Resident 2 would go inside other residents' room the whole time Resident 2 was in the facility. CNA 1 stated Resident 2 had a habit of touching and stealing things from other resident rooms. CNA 1 stated when residents in the facility reported missing items, the staff would go and check Resident 2's room first. During an interview on 5/15/2025 at 1:47 PM with the Director of Nursing (DON), the DON stated residents have that right to privacy which includes the right to restrict anyone's access to their rooms. The DON stated residents had the right to refuse entry to their rooms and to determine who may visit them. The DON stated the residents' rights were important for the residents' safety and their privacy. During a record review of the facility's policy and procedure (P&P) titled, Privacy and Dignity, revised 11/1/2017, the policy indicated residents' care and services provided by the facility promote and/or enhance privacy, dignity and overall quality of life. During a record review of the facility's P&P titled, Resident Rights, revised 11/1/2017, the policy indicated the facility must treat each resident with respect and dignity and care for each resident in a manner in an environment, that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality.

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44636 Based on observation, interview, and record review, the facility failed to follow its policy and procedure to ensure an allegation of physical abuse (willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish) was reported to California Department of Public Health (CDPH), local law enforcement, and Ombudsman within two (2) hours for two of two residents (Residents 1 and 2). This deficient practice had the potential to place Resident 1 and other residents in the facility at risk for further abuse and resulted in a delay in the investigation for the abuse allegation. Findings: During a review of Resident 1's Admission Record, the Admission Record indicated Resident 1 was admitted to the facility on [DATE] with the diagnoses including but not limited to type 2 diabetes mellitus (a disease that occurs when there is a problem in the way the body regulates and uses sugar as fuel), end stage renal disease (advanced stage kidney failure) and hypertension (high blood pressure). During a record review of Resident 1's Minimum Data Set (MDS, a resident assessment and tool), dated 4/15/2025, the MDS indicated the resident's cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decision making were moderately impaired. The MDS indicated Resident 1 was dependent (helper does all the effort, resident does none of the effort to complete the activity) for toileting and shower/bathing self. The MDS also indicated Resident 1 required substantial/maximal assistance (helper does more than half the effort) for rolling left and right, sitting to lying, and lying to sitting on side of bed. During a record review of Resident 1's care plan, dated 5/10/2025, the care plan indicated Resident 1 stated male resident went into her room and touched her gown and leg. The care plan interventions for staff were to monitor resident for mood regarding male going into her room, keep resident safe and assign Certified Nurse Assistant (CNA) for 1:1 close monitoring. During a record review of Resident 1's SBAR (an acronym for Situation-Background-Assessment-Recommendation is a technique used to provide a framework for communication between members of the health care team), dated 5/10/2025, the SBAR indicated Resident 1 verbalized another resident went into her room and touched her leg and gown. During a record review of Resident 1's Nursing Note, dated 5/10/2025, the record indicated Resident 1 reported to CNA 1 that a male resident was in her room around 7:30 PM. CNA 1 pulled Resident 2 out of room and reported to charge nurse. During a record review of Resident 1's Nursing Note, dated 5/10/2025, the record indicated Resident 1's responsible party (RP) called the facility and verbalized there was a man that went inside Resident 1's room and touched her. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 2's Admission Record, the Admission Record indicated Resident 2 was admitted to the facility on [DATE] with the diagnoses including but not limited to encephalopathy (brain disease, damage, or malfunction that results in an altered mental state), schizophrenia (a chronic and severe mental disorder that affects how a person thinks, feels, and behaves), and bipolar disorder (mental disorder characterized by episodes of mania [extreme highs] and depression [extreme lows]). During a record review of Resident 2's MDS, dated [DATE], the MDS indicated the resident's cognitive skills for daily decision making were moderately impaired. The MDS indicated Resident 2 required partial/moderate assistance for toileting hygiene, shower/bathing self, personal hygiene, sit to lying, walking ten feet, and wheeling 50 feet with two turns using a manual wheelchair. During a record review of Resident 2's care plan, dated 5/11/2025, the care plan indicated Resident 2 was noted going into female room. The care plan interventions for staff were to explain/reinforce why behavior is inappropriate and/or unacceptable to the resident, physician made aware with order to transfer to hospital, and resident placed on 1:1 monitoring. During a record review of Resident 2's SBAR, dated 5/10/2025, the record indicated Resident 2 went into female room. Resident 2 was noted by CNA 1 to go into room, per Resident 1, Resident 2 touched her gown and leg. During an interview on 5/13/2025 at 12:09 PM with Licensed Vocational Nurse 1 (LVN 1), LVN 1 stated CNA 1 informed her CNA 1 pulled Resident 2 out of Resident 1's room via his wheelchair around 7:30 PM. LVN 1 stated Resident 1 said that Resident 2 had touched her leg and gown. LVN 1 stated she did not report the abuse at that time since LVN 1 was still passing medications to the residents. LVN 1 stated Resident 1's RP called to report Resident 1's allegation of abuse around 9:30 PM. LVN 1 stated LVN 2 had reported the allegation of abuse to the administrator (ADM) around 9:35 PM to 9:40 PM after receiving the call from RP. LVN 1 stated she should have informed LVN 2 to report the allegation of abuse to the ADM since she was busy with passing medications, but she did not. During a concurrent observation and interview on 5/13/2025 at 12:30 PM with Resident 1 in Resident 1's room, Resident 1 stated Resident 1 was lying on her bed facing the wall when Resident 2 came in and started touching her right knee up to the midthigh. Resident 1 stated it made her feel really uncomfortable. Resident 1 stated she was not able to get up and feared Resident 2 would beat her up if she did something to Resident 2. During an interview on 5/13/2025 at 1:32 PM with LVN 2, LVN 2 stated Resident 1's RP called and informed LVN 2 about the allegation at 9:30 PM. LVN 2 stated Resident 1 informed him Resident 1 was lying on the bed and felt someone touch her leg turned around and saw a man. LVN 2 stated after the investigation, he called and informed the ADM. LVN 2 stated an allegation when reported by the resident was supposed to be reported within two hours. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 5/13/2025 at 2:49 PM with the Director of Nursing (DON) of Resident 1's Nursing Notes, the DON stated on 5/10/2025 Resident 1 report to CNA that a male resident was in her room around 7:30 PM. CNA 1 pulled Resident 2 out of room and reported to charge nurse. LVN 2 went to speak with Resident 1, Resident 1 verbalized that she was facing the wall and felt someone touch her leg and gown. The DON stated DON was aware of the incident around 10 PM on 5/10/2025. The DON stated reporting time was within 2 hours of when the resident made the claim Resident 2 touched Resident 1's leg. The DON stated staff needed to notify the administrator within 2 hours to ensure the residents were safe. The DON stated when Resident 2 touched Resident 1's leg this was considered sexual abuse. The DON stated this occurred at 7:30 PM, so the facility needed to report the abuse by 9:30 PM. The DON stated the abuse allegation was reported at 11:11 PM which was almost four hours later. During a concurrent record review of the facility's policy and procedure (P&P) with the DON, the DON stated the allegation should be reported immediately but no later than two hours after forming the suspicious of the alleged violation involving abuse to the state survey agency, law enforcement, and the ombudsman. During an interview on 5/13/2025 at 3:40 PM with the ADM, ADM stated LVN 1 and 2 spoke to him around 9:30 PM regarding the incident that had occurred. ADM stated LVN 1 did not and should have informed him the incident happened at 7:30 PM and made the report during this time. During a record review of the facility's P&P titled, Abuse Prevention and Prohibition Program, revised 8/1/2023, the policy indicated the facility will report allegations of abuse immediately, but no later than 2 hours after forming the suspicion - if the alleged violation involves abuse or results in serious bodily injury to the state survey agency, law enforcement, and the Ombudsman.