

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055617	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/12/2025
NAME OF PROVIDER OR SUPPLIER Pasadena Grove Health Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0580 Level of Harm - Actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0580 Level of Harm - Actual harm Residents Affected - Few	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record reviews, the facility failed to immediately inform the physician of one of two sampled residents (Resident 1), who had a diagnosis of hypertension (high blood pressure) and cerebral infarct (the death of brain tissue from a sudden blockage of blood flow, depriving brain cells of oxygen and nutrients) of Resident 1's change of condition by failing to: 1. Ensure the physician was notified by licensed nurse when Resident 1 was reported by Certified Nurse Assistant (CNA) 1 that Resident 1 was sleepier than usual on 12/7/2025 and 12/8/2025. 2. Ensure Licensed Vocational Nurse 1 (LVN 1) notified Resident 1's physician timely within 15 minutes from when Resident 1 had a change of condition when Resident 1 was assessed to have a blood pressure (BP) of 153/91 millimeters of mercury (mmHg - a standard unit of measuring blood pressure. Normal blood pressure for adults is generally considered less than 120/80 mm Hg) on 12/8/2025 at 8:07 AM. As a result, Resident 1's BP went up to 210/92 mmHg (it is considered hypertensive emergency [a severe, sudden spike in blood pressure over 180/120 mmHg that can cause damage to organs like the brain such as intracranial hemorrhage {brain bleed- this is a life-threatening neurological emergency, often called a hemorrhagic stroke, where uncontrolled high blood pressure damages arteries, leading to bleeding into the brain tissue}] because the extreme pressure overwhelms brain blood vessels, causing them to weaken, rupture, and leak blood), was assessed to be lethargic (lack of energy and decrease in consciousness), and was unable to respond verbally on 12/8/2025 at 1 PM. Resident 1 was then transferred to General Acute Care Hospital (GACH) via 911 emergency services (EMS - provides emergency medical care) on 12/8/2025 at 2 PM and was admitted to the GACH's Emergency Department (ED). While in GACH, Resident 1 underwent Computerized Tomography scan (CT scan - imaging using x-ray [a photographic or digital image of the internal composition of a part of the body] technique to create detailed images of the body) of the head in GACH and result showed bleeding in the cerebral hemisphere (half of a brain, right or left) of 7.4 centimeters (cm- unit of measure) in craniocaudal (measuring from the head down) by 2.7 cm by 3.5 cm in the transverse dimension (a measurement or direction across). Resident 1 was intubated (breathing tube has been inserted into the windpipe to keep the airway open) in the GACH's ED and admitted to the intensive care unit (ICU - a department in the hospital in which patients who are dangerously ill are kept under constant observation) with acute intracranial hemorrhage. Findings: During a review of Resident 1's admission Record, the admission Record indicated the resident was originally admitted at the facility on 4/18/2025 with the following but not limited to diagnoses of hypertension, anxiety (feeling of worry or fear, but when it is excessive, persistent, and interferes with daily life) and cerebral infraction. During a review of Resident 1's Minimum Data Set (MDS - a resident assessment tool), dated 12/1/2025, the MDS indicated the resident was severely impaired in cognitive (the ability to understand and make decisions) skills for daily decision making. The MDS also indicated Resident 1 required substantial/maximal assistance (helper does more than half the effort. Helper lifts or holds trunk or limbs and provides more than half the effort) with sit to lying, lying to sitting on side of bed, sit to stand, chair/bed to chair transfer, walking 10 feet, eating and upper body dressing. The MDS indicated Resident 1 is dependent (Helper does all of the effort. The resident does none of the effort to complete the activity. Or, the assistance of 2 or more helpers is required for the resident to complete the activity) with oral hygiene, toileting hygiene, shower/bathe self, lower body dressing and putting on/taking off footwear. During a review of Resident 1's Weights and Vitals Summary dated 12/8/2025 indicated Resident 1's BP read 153/91 mmHg at 8:07 AM. During a review of Resident 1's Progress Notes, dated 12/8/2025 from 10:11 AM to 10:12 AM, the progress notes indicated Resident 1 refused medication, offered three times, physician made aware. The progress notes did not specify the physician was made aware regarding Resident 1's elevated BP of 153/91 mmHG. During a review of Resident 1's Progress Notes, dated 12/8/2025 at 1:00 PM, the Progress Notes indicated the resident was sleepy and refused to open his mouth. During a review of Resident 1's Weights and Vitals Summary dated 12/08/2025 at 1:00 PM, it indicated Resident 1's BP was 210/92 mmHg. During a review of Resident 1's SBAR (situation, background, assessment, recommendation-a communication tool used by healthcare workers when there is a change of condition [is a significant, sudden shift in a person's physical, mental, behavioral, or functional state from their baseline, requiring clinical attention] among the residents), dated 12/8/2025, the SBAR indicated the resident refused lunch and was sleepy. The SBAR indicated Resident 1 refused to open mouth when given medication at 1 PM and was very lethargic and was unable to respond verbally. During a review</p>		