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	12/19/2025

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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. (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 0607 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 interview and record review, the facility failed to implement the facility's policy and procedure (P&P) for abuse for two (2) of two sampled residents when the facility failed to investigate an allegation of abuse by Resident 2 to Resident 1 on 12/18/2025. On 12/18/2025, Resident 1 reported to Registered Nurse 1 (RNS 1) that Resident 1 was getting harassed (to experience persistent, unwelcome conduct that is offensive, intimidating, or humiliating, often targeting a person's protected traits like race, gender, or religion, or simply making them feel threatened, distressed, or that creates a hostile environment) and assaulted (threatening or attempting to physically harm someone, causing them to reasonably fear immediate injury, even without actual contact) by Resident 2. This failure has the potential for Resident 1 and Resident 2 to feel unsafe and at risk of further abuse in the facility.Findings: 1.During a review of Resident 1's admission Record, the admission Record indicated Resident 1 was admitted to the facility on [DATE] with diagnoses that included type 2 diabetes mellitus (DM- a disorder characterized by difficulty in blood sugar control and poor wound healing), essential hypertension (HTN- high blood pressure), and schizoaffective disorder (a mental health problem where a person experiences loss of contact with reality as well as mood symptoms). During a review of Resident 1's Minimum Data Set (MDS- a resident assessment tool), dated 12/13/2025, the MDS indicated Resident 1 was assessed having moderately impaired cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decision making. The MDS indicated Resident 1 required supervision or touching assistance with eating, oral/toileting hygiene, upper/lower body dressing, putting on/taking off footwear, sit- to- lying, sit- to- stand, and toilet transfer. The MDS indicated Resident 1 required partial/moderate assistance (helper does less than half the effort) with shower/bathe self. 2. During a review of Resident 2's admission Record, the admission Record indicated Resident 2 was initially admitted to the facility on [DATE] and was readmitted on [DATE] with diagnoses that included malignant neoplasm of vulva (a rare cancer of the external female genital), chronic diastolic heart failure (when the heart muscle gets stiff making it hard to relax and fill with enough blood between beats), and cardiomegaly (enlarged heart). During a review of Resident 2's MDS, dated [DATE], the MDS indicated Resident 2 was assessed having moderately impaired cognitive skills for daily decision making. The MDS indicated Resident 2 required supervision or touching assistance with eating. The MDS also indicated Resident 2 required partial/moderate assistance with oral/toileting/personal hygiene, upper/lower body dressing, sit- to- stand, and toilet transfer. During an interview on 12/19/2025, at 12:50 PM, with Resident 1, Resident 1 stated, on 12/16/2025 (unable to recall time), Resident 1 saw Resident 2 go through her clothes. Resident 2 punched Resident 1 on the chest when Resident 1 told Resident 2 to stop. Resident 1 stated Resident 2 called her a [NAME] (a derogatory slang term often used for a promiscuous woman) and told her to kiss Resident 2's black ass. Resident 1 stated she reported the incident to RN 1 on 12/18/2025 (unable to recall time). During an interview on 12/19/2025, at 2:41 PM, with Licensed Vocational Nurse 1 (LVN 1), LVN 1 stated if Resident 1 reported to the staff that the resident was hit by another resident, then the staff should report the incident to the abuse coordinator and the three State Agencies (CDPH, local PD and Ombudsman). LVN 1 stated it was the facility's policy to report suspected abuse to the abuse coordinator right away and to investigate any allegation of abuse. During a concurrent interview and record review on 12/19/2025, at 3:02 PM, with Social Services Director (SSD), Resident 1's Progress Note, dated 12/18/2025, was reviewed. SSD stated the Progress Note indicated Resident 1 was assaulted by another resident (Resident 2) and Resident 1 had called the police and CDPH on 12/18/2025. SSD stated she was not informed that Resident 1 reported getting assaulted by Resident 2. SSD stated she was not informed that Resident 1 called the police and the police came and talked to Resident 1 on 12/18/2025. SSD stated RNS 1 should have reported Resident 1's abuse allegation to the abuse coordinator and the Director of Nursing (DON) or the ADM will then start and conduct an investigation about the abuse incident to find out what happened. SSD stated it was important to report abuse to the State Agencies, to investigate thoroughly and to have documentation on what took place and to ensure the safety of the residents involved. During an interview on 12/19/2025, at 3:24 PM, with RNS 1, RNS 1 stated on 12/18/2025, Resident 1 was agitated and upset about her HTN medication. RNS 1 stated while she was trying to calm Resident 1 down, Resident 1 informed her that Resident 1 was being harassed in the facility and was assaulted by Resident 2. RNS 1 did not report Resident 1's allegation of abuse by Resident 2 to the Administrator (ADM). RNS 1 stated that according to the facility's abuse policy, any report

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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. (continued on next page)

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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	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to report an alleged abuse (willful infliction of injury resulting to physical harm/pain or mental anguish) to the State Survey Agency (California Department of Public Health-CDPH- where state law provides for jurisdiction in long-term care facilities), Ombudsman (OMB- advocates for residents of nursing homes, board and care homes and assisted living facilities), and local law enforcement (PD) within two (2) hours after the allegation of abuse was reported to Registered Nurse Supervisor 1 (RNS 1) for two of two sampled residents (Resident 1 and 2) This deficient practice had the potential to place Resident 1 and 2 at risk for further abuse and/or under reporting from the facility.Findings: 1. During a review of Resident 1's admission Record, the admission Record indicated Resident 1 was admitted to the facility on [DATE] with diagnoses that included type 2 diabetes mellitus (DM- a disorder characterized by difficulty in blood sugar control and poor wound healing), essential hypertension (HTN- high blood pressure), and schizoaffective disorder (a mental health problem where a person experiences loss of contact with reality as well as mood symptoms). During a review of Resident 1's Minimum Data Set (MDS- a resident assessment tool), dated 12/13/2025, the MDS indicated Resident 1 was assessed having moderately impaired cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decision making. The MDS indicated Resident 1 required supervision or touching assistance with eating, oral/toileting hygiene, upper/lower body dressing, putting on/taking off footwear, sit- to- lying, sit- to-stand, and toilet transfer. The MDS indicated Resident 1 required partial/moderate assistance (helper does less than half the effort) with shower/bathe self. 2. During a review of Resident 2's admission Record, the admission Record indicated Resident 2 was initially admitted to the facility on [DATE] and was readmitted on [DATE] with diagnoses that included malignant neoplasm of vulva (a rare cancer of the external female genital), chronic diastolic heart failure (when the heart muscle gets stiff making it hard to relax and fill with enough blood between beats), and cardiomegaly (enlarged heart). During a review of Resident 2's MDS, dated [DATE], the MDS indicated Resident 2 was assessed having moderately impaired cognitive skills for daily decision making. The MDS indicated Resident 2 required supervision or touching assistance with eating. The MDS also indicated Resident 2 required partial/moderate assistance with oral/toileting/personal hygiene, upper/lower body dressing, sit- to- stand, and toilet transfer. During an interview on 12/19/2025, at 12:50 PM, with Resident 1, Resident 1 stated, on 12/16/2025 (unable to recall time), Resident 1 saw Resident 2 go through her clothes. Resident 2 punched Resident 1 on the chest when Resident 1 told Resident 2 to stop. Resident 1 stated Resident 2 called her a hoe (a derogatory slang term often used for a promiscuous woman) and told her to kiss her black ass. Resident 1 stated she called the PD and reported the abuse incident with Resident 2 to RNS 1 on 12/18/2025. During an interview on 12/19/2025, at 2:08 PM, with Certified Nursing Assistant 1 (CNA 1), CNA 1 stated, facility staff were all mandated reporters (a person who is legally required to report known or reasonably suspected abuse to authorities). CNA 1 stated suspected abuse, or an allegation of abuse should be reported to CDPH, Ombudsman, and police immediately or within two hours from the incident or from when the staff was made aware. During an interview on 12/19/2025, at 2:24 PM, with CNA 2, CNA 2 stated abuse should always be reported to the three State Agencies for the safety of the residents. CNA 2 stated that abuse should be reported immediately or within two hours even if it was not witnessed by staff. During an interview on 12/19/2025, at 2:41 PM, with Licensed Vocational Nurse 1 (LVN 1), LVN 1 stated if Resident 1 reported to the staff the resident was hit by another resident, then the staff should report the incident to the abuse coordinator and the three State Agencies (CDPH, local PD and Ombudsman). LVN 1 stated it was the facility's policy to report suspected abuse to the abuse coordinator and the three State Agencies right away or within two hours of the incident. During a concurrent interview and record review on 12/19/2025, at 3:02 PM, with Social Services Director (SSD), Resident 1's Progress Note dated 12/18/2025, was reviewed. SSD stated the Progress Note indicated Resident 1 was assaulted by another resident (Resident 2) (date of assault not indicated) and Resident 1 had called the police and CDPH on 12/18/2025. SSD stated she was not informed that on 12/18/2025, Resident 1 reported getting assaulted by Resident 2 to RNS 1. SSD stated she was not informed that Resident 1 called the police and the police came and talked to Resident 1 on 12/18/2025SSD stated Resident 1's abuse allegation should have been reported to the State Agencies immediately or within two hours after the allegation was reported. SSD stated it was important to report abuse to the State