

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  02/18/2026
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)		
<p>F 0842</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Some</p>	<p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on interview and record review, the facility failed to provide accurate documentation for the resident's Physician Discharge Summary and behavior monitoring for one (1) of two (2) sampled residents (Resident 1). This deficient practice had the potential to affect the accuracy of clinical assessments and medical management for Resident 1. Findings: During a record 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 dementia (progressive brain disorder that slowly destroys memory and thinking skills) with other behavioral disturbance, schizoaffective disorder (a mental illness that causes loss of contact with reality), bipolar disorder (mental disorder characterized by episodes of mania [extreme highs] and depression [extreme lows]), and anxiety disorder (persistent and excessive worry that interferes with daily activities). During a record review of Resident 1's Care Plan, dated 12/13/2025, the Care Plan indicated resident noted with verbal aggression towards staff/Certified Nursing Assistant (CNA) and racial remarks related to mental/emotional illness and poor impulse control. The Care Plan also indicated the interventions for staff were to administer medications as ordered and monitor/document for side effects and effectiveness. During a record review of Resident 1's Care Plan, dated 12/15/2025, the Care Plan indicated verbal behavior symptoms directed towards others screaming at others and accusing staff that they are hurting her. The Care Plan interventions for staff were to monitor the time and day when behavior occurs, administer medication as ordered and monitor for adverse side effects. During a record review of Resident 1's Minimum Data Set (MDS, a resident assessment and tool), dated 1/6/2026, the MDS indicated the resident's cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decision making was intact. The MDS indicated Resident 1 had mood symptoms and verbal behavior symptoms directed towards others. During a record review of Resident 1's Medication Administration Record (MAR, a medical record used by healthcare providers to document the administration of a medication or treatment) for the month of January 2026, the MAR indicated as follows: for all three shifts (day, evening, and night shift), monitor episodes of mood swings manifested by aggressive behavior towards others tally by hashmarks every shift. The MAR indicated Resident 1 did not have any mood swing episodes from 1/2/2026 to 1/22/2026. From 1/2/2026 to 1/22/2026, Risperidone (antipsychotic medication that works by changing the effects of chemicals in the brain) oral tablet 2 milligrams (mg, unit of measurement) - Give one tablet by mouth two times a day for schizoaffective disorder manifested by aggressive behavior. During a record review of Resident 1's Elopement Risk Assessment, dated 1/31/2026, the assessment indicated Resident 1 was at low risk for elopement. During a record review of Resident 1's Care Plan, dated 1/31/2026, the Care Plan indicated Resident 1 had inappropriate behavior manifested by verbally aggressive behavior to staff accusing staff. The Care Plan goal was for Resident 1's behavior manifested to be reduced from three to one per week till stable.</p> <p>(continued on next page)</p>		

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: 055617
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<p>F 0842</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Some</p>	<p>During a record review of Resident 1's Physician Discharge Summary, undated, the summary indicated Resident 1 was discharged to another facility on 2/2/2026 due to attempts to elope (leave the facility without the staff's knowledge and/or supervision). During an interview on 2/12/2026 at 12:43 PM with Social Services (SS), SS stated Resident 1 resided at the facility for about two months going in and out of the facility due to the resident's behaviors and verbally abusive and combative. During an interview and record review on 2/18/2026 at 12:49 PM with the Director of Nursing (DON), Resident 1's Change of Condition (COC, tool used by health care professionals when communicating about critical changes in a resident's status), dated 12/19/2025 and 1/30/2026 were reviewed. The COC indicated Resident 1 was transferred to the hospital on [DATE] due to the resident's aggressive behavior. The DON stated Resident 1 had verbal aggression towards staff, screaming and talking on the phone in the hallways, and verbally aggressive when medication was given. Resident 1's COC, dated 1/30/2026, indicated Resident 1 was verbally aggressive and accused staff of stealing the resident's clothes. The DON stated Resident 1 had been transferred out to the hospital due to the resident's behavior on 12/18/2025 and 1/22/2026. During a concurrent interview and record review on 2/18/2026 at 3:05 PM with the Registered Nurse Supervisor (RNS), Resident 1's medical records dated from 12/9/2025 to 2/2/2026 were reviewed. RNS stated Resident 1 was readmitted to the facility on [DATE] and was at low risk for elopement. RNS stated a record review of Resident 1's COCs and Nursing Notes did not indicate Resident 1 had attempted to elope from the facility from 1/30/2026 to 2/2/2026. During an interview on 2/18/2026 at 3:27 PM with SS, SS stated Resident 1 was verbally abusive towards staff and resident. SS stated she noted Resident 1 was getting aggressive with the CNAs when Resident 1 was readmitted to the facility on [DATE]. During an interview on 2/18/2026 at 4:24 PM with CNA 1, CNA 1 stated Resident 1 was usually aggressive towards residents and staff. CNA 1 stated Resident 1 would call all the CNAs derogatory names, and all the staff were aware of her behavior. CNA 1 stated Resident 1 would have aggressive behavior about three times a week. CNA 1 stated the aggressive behavior would last from morning till the afternoon. CNA 1 stated Resident 1's normal behavior would be to go to the nurses' station where she would fight with the Licensed Vocational Nurses. CNA 1 stated, Resident 1 has been having this behavior every day since December of last year (2025). During a concurrent interview and record review on 2/18/2026 at 4:34 PM with the DON, the DON stated on Physician Discharge Summary, it indicated Resident 1 was discharged due to attempts to elope. The DON stated the reason for the discharge was for aggressive behavior and not due to attempts to elope. The DON stated Resident 1's Physician Discharge Summary was inaccurate because the resident did not elope and the correct reason for the resident's discharge was because of the resident's aggressive behavior. During an interview on 2/18/2026 at 4:37 PM with the DON, the DON stated sometimes Resident 1 could be heard screaming at the CNAs and Licensed Nurses. The DON stated Resident 1 especially screamed at the Licensed Nurses when the licensed nurses were giving Resident 1 her medications. The DON stated when there was an episode of these behaviors (screaming at staff/ verbal aggression) during a shift, the licensed nurses should have included a hashmark/ tally for each episode in Resident 1's MAR. The DON stated Resident 1's aggressive behavior episodes needed to be documented to be aware of the resident's care and to determine if the medication was helping the resident and to inform the physician so the physician could determine if the medication needed to be changed and another medication added if Resident 1 was having continuous episodes. During the same interview and concurrent record review on 2/18/2026 at 4:37 PM with the DON Resident 1's MAR for January 2026 was reviewed. The DON stated Resident 1's MAR did not indicate there were tally marks/ hashmarks for Resident 1's aggressive behavior in January. The DON stated Resident 1 did have aggressive behaviors noted by the facility staff on</p> <p>(continued on next page)</p>		

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<p>F 0842</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Some</p>	<p>the month of January 2026, however it was not documented in the resident's MAR. The DON further stated, since it as not documented in the MAR there is a risk for inaccurate treatment or plan of care for Resident 1 to manage Resident 1's aggressive behavior. During a record review of the facility's policy and procedure titled, Documentation - Nursing, revised 11/1/2017, the policy indicated nursing documentation will be concise, clear, pertinent, and accurate.</p>