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	05/13/2026

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 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from the wrongful use of the resident's belongings or money. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to prevent misappropriation of property (the deliberate misplacement, exploitation, or wrongful, temporary, or permanent use of a resident's belongings or money without the resident's consent) for one (1) of six (6) sampled residents (Resident 1). This failure resulted in the loss of Resident 1's cell phone and laptop, the transfer of funds from Resident 1's bank account to Certified Nurse Assistant 2's (CNA 2) bank account and a credit card account being opened and mailed to CNA 2's address.During a review of Resident 1's admission Record, the admission Record indicated the resident was initially admitted to the facility on [DATE] and readmitted [DATE] with diagnoses of chronic obstructive pulmonary disease (COPD; a chronic lung disease causing difficulty in breathing) with acute (short-term) lower respiratory infection (inflammation of the large airways of the lung), and pneumonia (an infection of one or both lungs that causes the tiny air sacs [alveoli] to become inflamed and fill up with fluid or pus). During a review of Resident 1'S Minimum Data Set (MDS - a resident assessment tool), dated 4/10/2026, the MDS indicated the resident was moderately impaired with cognitive (ability to think, remember, and reason) skills for daily decision making. Resident 1 was dependent (helper does all of the effort. Resident does none of the effort to complete the activity) with putting on/taking off footwear and lower body dressing (the ability to dress and undress below the waist). MDS also indicated Resident 1 needed substantial/maximal assistance (helper does more than half the effort) with going from lying to sitting at the side of the bed, rolling left and right in bed and upper body dressing (the ability to dress and undress above the waist) and needed supervision or touching assistance (helper provides verbal cues and/or touching steadying and/or contact guard assistance) with eating. During a review of Resident 1's Progress Note, dated 5/4/2026, Resident 1's Progress Note indicated on 5/4/2026, the Social Services Director (SSD) reported an allegation involving potential financial exploitation (the act of treating someone unfairly or taking advantage of them for one's own personal, financial, or selfish benefit) of a deceased resident (Resident 1). The note indicated a friend of Resident 1 informed the facility that an employee appears to have made two unauthorized [NAME] (money transfer company) transactions from the resident's bank account and additionally, a new credit card was also reportedly ordered under that employee's name. During an interview on 5/13/2026 at 11:40 AM with the Administrator (ADM), ADM stated on 5/4/2026, the ADM was notified by Resident 1's friend over the phone that a few days after the resident's death on 4/20/2026, she noticed some [NAME] transactions on the resident's email that were sent to a phone number and a name she did not recognize. ADM stated he spoke with the facility's Business Office Manager (BOM) and confirmed the name, and phone number was CNA 2's. Resident 1's friend also mentioned there was a credit card application that was submitted under Resident 1's name and approval was being sent to an address that was near the facility's address. ADM stated upon checking CNA 2's records, it was found the mailing address was CNA 2's address as well. ADM further stated that upon interviewing CNA 2, CNA 2 verified her phone number and mailing address as the same that were used in the [NAME] transactions and the credit card application. ADM stated CNA 2 had told himself, the Director of Nursing (DON), Human Resources (HR), Director of Staff Development (DSD), and SSD, that there was (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 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	an instance where she allowed Resident 1 to use her personal phone, and she had stated that she did not notify any supervisor of the incident. During an interview on 5/13/2026 at 1:56 PM with DSD, DSD stated facility's policy is to prevent financial abuse. DSD stated staff are not to take anything they receive from the residents such as gifts. DSD further stated that the nursing department was instructed never to handle any money or deal with residents' financial matters or bank accounts. DSD stated if a resident attempts to hand money to staff when the BOM or SSD is not in the facility, they are to keep it locked and secured inside the nurse's cart. DSD stated they are not to handle any amount over $20.00.During an interview on 5/13/2026 at 4:06 PM with Resident 1's Friend, Resident 1's Friend stated she first noticed an email sent to Resident 1 from Resident 1's bank on 4/26/2026 indicating [NAME] had been set up and CNA 2 was added as a [NAME] recipient, with a $200.00 [NAME] payment sent to CNA 2 on the same day. Resident 1's friend further stated that on 4/27/2026, there was another email from the bank indicating a [NAME] payment of $120.00 was sent to CNA 2. Additionally, Resident 1's Friend stated that a credit card had been opened under Resident 1's name with his bank and the card was being mailed to CNA 2's address. During an interview on 5/13/2026 at 4:23 PM with CNA 2, CNA 2 stated that her only relationship with Resident 1 was as his CNA and nothing more. CNA 2 stated Resident 1 never asked her to buy anything for him other than chips from the vending machine and that she never handled more than $2.50 in cash, which was the cost of the chips Resident 1 requested. CNA 2 also stated she never had access to Resident 1's phone information but admitted that on one occasion she allowed Resident 1 to use her personal phone to help her with a phone backup (making a copy of one's phone data) and to download the TikTok (a global social media platform where users create, watch, share short-form videos and purchase products) application onto her personal phone. CNA 2 stated she has Resident 1's personal phone number so the resident could contact her at any time. CNA 2 stated there were [NAME] transactions transferred to her account from Resident 1's account for $200.00 and $120.00 on 5/5/2026. CNA2 stated she called her bank to report that she was not expecting those transactions and to have them removed from her account. CNA 2 verified her current phone number and address and stated she did not apply for any credit card under Resident 1's name and had not received any credit card in the mail.During an interview on 5/13/2026 at 4:42 PM with ADM, ADM stated during their interview with CNA 2 on 5/4/2026, CNA 2 had told them there was an instance where Resident 1 had downloaded the TikTok application onto CNA2's personal phone. ADM stated according to CNA 2, besides providing activities of daily living (ADL) care for Resident 1, she would also order food from outside source and get him items such as vitamins from a store outside the facility. The ADM stated that staff are permitted to purchase items for a resident if the resident has no family or friends available to do so; however, all transactions must be handled in cash and must be logged and witnessed by the SSD or DON during the cash exchange and again when the goods and change are returned. During the same interview and record review on 5/13/2026 at 4:42 PM with ADM, the Facility's policy and procedure (P&P) titled, Abuse Prevention and Prohibition Program, revised 8/1/2023, was reviewed. ADM stated it is the facility, as an entity's responsibility to protect and prevent abuse to a resident.During an interview on 5/13/2026 at 5:18 PM with SSD, SSD stated on 4/20/2026 when Resident 1 passed away, his belongings were inventoried (the process of taking a documented catalog of a resident's personal belongings) by a Restorative Nursing Assistant (RNA, a CNA with specialized training in rehabilitation). The RNA packed up Resident 1's belongings and placed them inside the closet in the resident's room. SSD stated once the RNA finished completing the inventory of Resident 1's belongings, the only item given to her was a yellow envelope containing Resident 1's identification card (ID), Social Security card, Medicare and Medi-Cal insurance cards, and his bank debit card. SSD stated the rest of Resident 1's belongings were packed into a box and placed in the closet inside Resident 1's room, an area accessible to other people, including staff. SSD stated Resident 1's box of belongings was not brought to her office for secure storage until 5/4/2026, when Resident 1's friend contacted the facility. Additionally, SSD stated the inventory of Resident 1's (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	belongings completed on 4/20/2026 accounted for Resident 1's cell phone and laptop; however, during another inventory conducted on 5/4/2026, Resident 1's cell phone and laptop were found to be missing.During a concurrent interview and record review on 5/13/2026 at 5:28 PM with SSD, Resident 1's Inventory List, dated 4/20/2026, was reviewed. Resident 1's Inventory List accounted for Resident 1's cell phone and laptop. SSD stated when she went through the 2 boxes where Resident 1's belongings were stored, everything was accounted for from the Inventory List on 4/20/2026 with the exception of the resident's cell phone and laptop.During a concurrent observation and interview on 5/13/2026 at 5:29 PM with SSD inside her office, the 2 boxes of Resident 1's belongings were observed to be missing the resident's cell phone and laptop as listed on the resident's inventory list on 4/20/2026. SSD stated that the usual procedure after a resident expires is to inventory their belongings and pack them into a box, which is typically stored in the SSD office. However, Residentˆ1's boxed belongings were left in the room's closet, an area that was unfortunately accessible to others, including staff. During an interview on 5/13/2026 at 5:31 PM with the ADM, ADM stated the normal procedure after a resident expires is to store their belongings in the SSD's office and contact the family to arrange pickup. However, in Residentˆ1's case, his belongings were left in his room. The ADM stated the facility did not become aware that Residentˆ1's phone was missing until 5/4/2026, when his friend reported it. The ADM stated Resident 1's belongings should not have been left in the resident's room's closet, as this exposed them to unauthorized access and placed Residentˆ1's phone and its information at risk. During a review of the facility's policy and procedure (P&P) titled, Abuse Prevention and Prohibition Program, revised 8/1/2023, the P&P indicated its purpose is To ensure the Facility establishes, operationalizes, and maintains an Abuse Prevention and Prohibition Program designed to screen and train employees, protect residents, and to ensure a standardized methodology for the prevention, identification, investigation, and reporting of abuse, neglect, mistreatment, misappropriation of property, and crime in accordance with federal and state requirements. The P&P also indicated:Each resident has the right to be free from abuse, neglect, mistreatment, and/or misappropriation of property. The facility has zero-tolerance for abuse, neglect, mistreatment, and/or misappropriation of resident property. Staff must not permit anyone to engage in verbal, mental, sexual, or physical abuse, neglect, mistreatment, or misappropriation of resident property.The facility is committed to protecting residents from abuse by anyone, including but not limited to Facility Staff, other residents, consultants, volunteers, staff from other agencies providing services under arrangement, family members, legal guardians, surrogate, sponsors, friends and visitors.During a review of the Facility's P&P titled, Theft/Loss Prevention, revised 11/1/2017, the P&P indicated its purpose, To assist residents in safeguarding their personal property. The P&P also indicated:The facility is committed to preventing the misappropriation of resident property. The facility will exercise reasonable care for the protection of the resident's property from theft or loss.

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure one (1) of two (2) sampled residents (Resident 2) was free from unnecessary psychotropic drugs (any medication capable of affecting the mind, emotions, and behavior) as indicated in the facility's policy and procedure by failing to ensure Resident 2 had a specific indication for the use of Buspirone Hydrochloride (HCL) (a prescription medication used to treat symptoms of generalized anxiety disorder[emotion characterized by feelings of tension, worried thoughts and physical changes]). This deficient practice had the potential to increase the risk of Resident 2 to experience adverse effects (unwanted, uncomfortable, or dangerous effects that a drug may have) related to psychotropic medication (drug or other substance that affects how the brain works and causes changes in mood, awareness, thoughts, feelings, or behavior), which may lead to an overall negative impact on the residents' physical, mental, and psychosocial well-being.Findings:During a review of Resident 2's admission Record, the admission Record indicated Resident 2 was initially admitted to the facility on [DATE]. Resident 2's diagnoses included chronic obstructive pulmonary disease (a progressive lung disease that makes it difficult to breathe), unspecified atrial fibrillation, (a diagnosis confirming an irregular, rapid heart rhythm), and difficulty in walking, not elsewhere classified. During a review of Resident 2's Minimum Data Set (MDS, resident assessment tool), dated 4/7/2026, the MDS indicated Resident 2 had moderately impaired cognitive skills (mental processes that allow people to think, learn, and solve problems) for daily decision making. The MDS indicated Resident 2 needed supervision or touching assistance, (helper provides verbal cues and /or touching/steadying and/or contact guard assistance as resident completes activity) for eating and oral hygiene. Resident 2 needed partial or moderate assistance, (helper does less than half the effort) with upper, lower body dressing, putting on/taking off footwear and sit to lying. The MDS also indicated Resident 2 needed substantial/maximal assistance (helper does more than half the effort. Helper lifts or holds trunks or limbs but provides more than half the effort) with toileting hygiene, shower/bath self and personal hygiene. MDS indicated Resident 2 had behavior symptoms. During a review of Resident 2's Medication Administration Record (MAR) dated from 4/1/2026 to 4/30/206 was reviewed. Resident 2's April 2026 MAR indicated Buspirone HCL oral tablet 2.5 milligrams (mg, unit of measurement) by mouth three times a day for anxiety manifested by restlessness, ordered on 4/4/2026 and discontinued on 4/15/2026. During a concurrent interview and record review on 5/13/2026 at 2:55 PM with the Licensed Vocational Nurse 1 (LVN 1), Resident 2's April 2026's MAR was reviewed. LVN 1 stated the indication and manifestation of restlessness for the medication of Buspirone can be interpreted as Resident 2 pressing on his call light without stopping. LVN 1 stated restlessness can be interpreted differently by other LVNs and the indications and manifestations of use for this medication were not specific. During a concurrent interview and record review on 5/13/2026 at 4:28 PM with the LVN 2, Resident 2's April 2026's MAR was reviewed. LVN 2 stated the indication and manifestation of restlessness for the medication of Buspirone can be interpreted as Resident 2 expressing frequent complaints for his stay at other convalescent homes. LVN 2 stated restlessness was not specific. During an interview on 5/13/2026 at 5:10 PM with the Director of Nursing (DON), the DON stated it was important to have a specific and accurate indication and manifestation for use of any psychotherapeutic medication to ensure the resident receives the correct medication for the correct indication. The DON stated psychotropic medication orders should have the resident's specific behavior manifestation in order for staff to observe the same behavior and be able to evaluate if the medication was effective or not. This would also ensure that the medication is necessary for the treatment of the resident. The DON stated Resident 2's Buspirone medication did not have specific indications and manifestations for his treatment. During a review of the facility's Policy and Procedure (P&P) titled, Psychotherapeutic Drug Management, Revised on (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1/5/2026. The P&P indicated, 'Unnecessary drugs are any drug when used in excessive close (including duplicate drug therapy); for excessive duration; without adequate monitoring; or without adequate indications for its use; in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the afore listed reasons. Procedure:The psychotherapeutic medication order will include the following information:Indications and manifestations of the disorder treated (i.e., auditory hallucinations, hitting others, refusing to eat, etc.)