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	06/11/2026

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to protect one of two residents (Resident 1) from abuse (the willful infliction or injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish) when Resident 2 allegedly threw a blanket over Resident's 1's head and hit Resident 1 with a metal object on 5/28/2026. This deficient practice resulted in Resident 1 having an abrasion (injury where top layer of skin is scraped or rubbed away due to friction against a rough surface) on the left cheek and a cut on the left upper lip with the potential for emotional and psychosocial (combined influence of psychological factors and the surrounding social environment on physical, emotional, and/or mental wellness) harm.During a review of Resident 1's admission Record, the admission Record indicated the facility admitted Resident 1 on 4/3/2026 with diagnoses including but not limited to epilepsy (brain condition that causes a person to have repeated, unprovoked seizures [sudden, uncontrolled surge or electrical activity in the brain causing changes in behavior, body movements, sensations, or levels of awareness]), chronic obstructive pulmonary disease (COPD-common lung disease causing restricted airflow and breathing problems), legal blindness (severe vision impairment), psychosis (mental health symptom where a person loses touch with reality), and mood disorder (mental health condition that primarily disrupts a person's emotional state, causing long periods of extreme sadness, extreme happiness, or both). During a review of Resident 1's Minimum Data Sheet (MDS-a resident assessment tool), dated 4/7/2026, the MDS indicated Resident 1 had moderately impaired cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decision making. The MDS indicated Resident 1 required substantial/maximal assistance (helper does more than half the effort) with eating, oral hygiene, upper body dressing, and rolling left to right. The MDS indicated Resident 1 was dependent (helper does all of the effort, resident does none of the effort to complete the activity, or the assistance of two or more helpers were required for the resident to complete the activity) with toileting and personal hygiene, shower/bathing self, lower body dressing, putting on/taking off footwear, sit to lying, and lying to sitting on the side of the bed. During a review of Resident 1's Change in Condition Evaluation (COC-a clinical assessment used to track, measure, and understand any sudden or significant shift in a person's health, behavior, or physical abilities), dated 5/28/2026, the COC indicated Resident 2 threw a blanket over Resident 1 then hit Resident 1 with two wheelchair foot rests. The COC also indicated Resident 1 sustained minor skin abrasion on the left cheek with minimal bleeding and the resident During a review of Resident 1's Care Plan, dated 5/28/2026, the care plan indicated Resident 1 was at risk for emotional harm and emotional distress related to the altercation and physical trauma from another resident. During a review of Resident 1's Skin Observation Tool, dated 5/29/2026, the Skin Observation Tool indicated Resident 1 had left face abrasion, right posterior hand trauma, and a cut on the left upper lip. During a review of Resident 2's admission Record, the admission Record indicated the facility initially admitted Resident on 10/14/2025 and readmitted on [DATE] with diagnoses including, but not limited to unspecified psychosis (a collection of symptoms that happen when a person has trouble telling the difference (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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	between what is real and what is not), anxiety disorder (persistent and excessive worry that interferes with daily activities), schizophrenia (a chronic and severe mental disorder that affects how a person thinks, feels, and behaves), and mood disorder (a mental health condition that primarily affects a person's emotional state). During a review of Resident 2's MDS, dated [DATE], the MDS indicated Resident 2 had moderately impaired cognitive skills for daily decision making. The MDS indicated Resident 2 had delusions (misconceptions or beliefs that are firmly held, contrary to reality). The MDS also indicated Resident 2 required supervision or touching assistance (helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes the activity) with eating, oral hygiene, rolling left to right, sit to lying, lying to sitting on the side of the bed. The MDS indicated Resident 2 required partial/moderate assistance (helper does less than half the effort) with toileting and personal hygiene, showing/bathing self, putting on/taking off footwear, upper and lower body dressing, sitting to standing, chair/bed to chair transfer, toilet transfer, and walking 10 feet (unit of measurement) and walking 50 feet with two turns. During a review of Resident 2's Progress Notes/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 5/28/2026, the SBAR indicated the COC reported were behavioral symptoms, physical aggression towards Resident 1, increased agitation towards others: threw a blanket over Resident 1's head and hit her (Resident 1) with two footrests, ran out of the room to the back gate. The progress notes also indicated that Resident 2 was escorted back inside the facility, Resident 2 threw linen carts and kitchen carts to the floor while screaming and spitting at staff. The progress notes further indicated the police arrested resident for assault with a deadly weapon (unable to confirm if referring to footrest). During a review of Resident 3's admission Record, the admission Record indicated the facility initially admitted Resident 3 on 9/3/2024 and readmitted on [DATE] with diagnoses including but not limited to congestive heart failure (a serious condition in which the heart does not pump as effectively as it should), COPD, chronic pulmonary edema (a long-term condition where excess fluid slowly builds up in the lungs' air sacs, making it progressively harder to breathe), and malignant neoplasm of the vulva (uncontrolled growth of abnormal cells on the external female genitalia). During a review of Resident 3's MDS, dated [DATE], the MDS indicated Resident 3 had moderately impaired cognitive skills for daily decision making. The MDS indicated Resident 3 required supervision or touching assistance with eating and required partial/moderate assistance with oral/toileting/personal hygiene, upper/lower body dressing, putting on/taking off footwear, roll left to right, sit to lying, lying to sitting on the side of the bed, chair/bed to chair transfer, toilet transfer, and tub/shower transfer. During a concurrent observation and interview on 6/11/2026 at 12:30 PM, inside Resident 1's room, Resident 1 was observed in bed and resting. Resident 1 stated on 5/28/2026 in the evening (cannot recall time), she was getting ready to sleep when she heard Resident 2 grunt and groan and suddenly a fabric material like a blanket was thrown over her head. Resident 1 stated she got hit with something hard like a metal object on the left cheek and she was able to block the second blow with her right hand and yelled for help. Resident 1 stated when she started yelling for help, Resident 2 stopped hitting her. Resident 1 stated she felt something like metal rods on top of her chest to her lap/legs. During the same interview on 6/11/2026 at 12:30 PM with Resident 1, Resident 1 stated she did not really feel safe right after the incident. During an interview on 6/11/2026 at 2:44 PM with Certified Nurse Assistant (CNA) 1, CNA 1 stated she was at the South Nurses' Station across Resident 1 and 2's room and she last saw Resident 1 and 2 around 9:50 PM to 10:05 PM. CNA 1 stated Resident 2 would scream at staff but has not hit someone before. CNA 1 stated on 5/28/2026, another CNA informed her that Resident 1 was screaming and CNA 1 went to Resident 1 and 2's room and when CNA 1 got into the room, Resident 2 was no longer in the room, and she called the Charge Nurse/Licensed Vocational Nurse (LVN) 1. During an interview on 6/11/2026 at 2:50 PM with Registered Nurse Supervisor (RNS), the RNS stated the incident between Resident 1 and 2 happened on 5/28/2026 around 10 PM to 10:15 PM when CNA 1 (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	reported to LVN 1 that Resident 2 hit Resident 1. RNS stated Resident 2 was not in the room when she got there but saw two wheelchair footrests on top of Resident 1's chest. RNS stated Resident 1 had a small cut on the resident's left cheek and left upper lip with small amount of blood. RNS stated Resident 2 went out the patio door and another staff found Resident 2 by the back gate when the alarm went off. RNS stated when Resident 2 was brought back inside the facility and was later taken by the police officer to the police station. During an interview on 6/11/2026 at 4:24 PM with LVN 1, LVN 1 stated CNA 2 notified her that she heard yelling from Resident 1's room and Resident 1 told CNA 2 that Resident 2 hit Resident 1. LVN 1 stated she immediately went to check and observed wheelchair footrests were on top of Resident 1's chest and there was blood on Resident 1's left upper lip and left cheek. LVN 1 stated Resident 2 remained quiet while being asked about the incident then suddenly became agitated, cursed staff and started spitting at them. LVN 1 stated Resident 2 was uncooperative and verbally aggressive to the police officers and Resident 2 was then taken to the police station. During a concurrent interview and record review on 6/11/2026 at 5:21 with the Director of Nursing (DON), Resident 2's Medication Administration Record (MAR-legal document that tracks medications given to a patient, including dosage, time, route, and who administered it) for 5/2026 and progress notes dated 5/17/2026 to 5/18/2026, 5/25/2026, 5/27/26 to 5/28/2026 were reviewed. The MAR indicated the following medications were refused by Resident 2: On 5/25/2026 for 5 PM dose, 5/27/2026 for the 9 AM and 5 PM doses and 5/28/2026 for the 9 AM dose of Zyprexa (used to treat schizophrenia, bipolar I disorder, and treatment-resistant depression) 5 milligrams (mg-a commonly used on medication labels to measure the weight of ingredients) and give one tablet by mouth two times a day for schizophrenia manifested by auditory hallucinations (false perception of hearing a sound in the absence of an external acoustic stimulus) On 5/25/2026 for the 5 PM dose, 5/27/2026 for the 9AM and 5 PM doses and 5/28/2026 for the 9 AM dose of Depakote (prescription medication primarily used as an anticonvulsant and mood stabilizer) 500 mg, give one tablet by mouth two times a day for mood disorder as evidenced by irritable mood. On 5/17/2026 for the 9 AM dose; 5/18/2026 for the 9 AM dose; 5/27/2026 for the 9 AM dose; and 5/28/2026 for the 9 AM dose of aripiprazole (sed to treat mental health conditions like schizophrenia, bipolar disorder, and major depressive disorder) 5 mg. Give one tablet by mouth daily for schizophrenia manifested by disorganized thinking Resident 2's progress notes dated 5/17/2026, 5/18/2026, 5/27/2026 to 5/28/2026 indicated documentation for administration notes as refused x 3 or refused x 3, risk and benefits discussed. The DON stated that there was no documentation that either Resident 2's physician (MD) or psychiatrist (medical doctor who diagnoses and treats mental, emotional, and behavioral disorders) was notified about the resident's refusal to take the medication in accordance with the facility's policy and procedure (P&P). The DON stated that MD notification was very important, especially since Resident 2 had been refusing three medications on multiple times leading to the day of the incident. The DON stated that the MD could have ordered other treatment alternatives to manage and control Resident 2's behaviors which could have potentially prevented the physical abuse by Resident 2. During a concurrent interview and record review on 6/11/2026 at 5:40 PM with the DON, the P&Ps titled Refusal of Treatment, revised 11/1/2017 and Care and Services, revised 11/1/2017, were reviewed. The P&P titled Refusal of Treatment indicated:The Charge Nurse of DON interviews the resident to determine what and why the resident is refusing treatment.The Attending Physician will be notified in a time frame determined by resident's condition.The P&P titled Care and Services indicated:Licensed Nurse or designee documents and notifies the Attending Physician of COC, including progress and/or decline in physical or mental function and refusal of care and services.The DON stated the P&Ps were not followed because the licensed nurses did not notify the MD when Resident 2 refused his Zyprexa, Depakote and aripiprazole on several occasions from 5/17/2026 to 5/28/2026, and if they were followed, it could have potentially prevented the abuse incident. During a concurrent interview and record review on 6/11/2026 at 5:54 PM with the DON, the Care Plan dated 3/2/2026 was reviewed. The Care Plan indicated Resident 2 has a mood problem related to (continued on next page)

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