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	04/03/2026

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to provide a safe environment that is free from accident hazards for two (2) of three (3) sample residents (Residents 44, and 9) reviewed for accident hazards by failing to ensure:A black synthetic gait belt (a type of belt used to support, steady, or assist a resident during movement), approximately five (5) feet long, was not left on the floor near Resident 44's bed.Resident 9's feet were not dangling while sitting in the wheelchair.The base of the Hoyer lift (a mechanical device designed to safely transfer individuals with limited mobility between surfaces, such as a bed, chair, or wheelchair) stored in the hallway was not left wide open. The lint trap was cleaned on 4/3/2026 at 8AM, 10AM, and 12PM from the facility's two of two dryer's machines (Dryer 1 and 2). These deficient practices placed Residents 44 and 9 and other residents at risk for serious injury. In addition, it placed the facility and the residents at risk for fire from Dryers 1 and 2. Findings: 1. During a review of Resident 44's admission Record, the admission Record indicated the resident was initially admitted to the facility on [DATE] and readmitted [DATE] with diagnoses of schizophrenia (a chronic and severe mental disorder that affects how a person thinks, feels, and behaves) and difficulty in walking. During a review of Resident 44'S Minimum Data Set (MDS – a resident assessment tool), dated 2/11/2026, the MDS indicated the resident had moderately impaired cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decision making. The MDS indicated Resident 44 used a walker and wheelchair as mobility devices. The MDS also indicated Resident 44 needs substantial / maximal assistance (helper does more than half the effort to walk 10 ft. (once standing, the ability to walk at least 10 ft in a room, corridor, or similar space). During a record review of Resident 44's Care Plan, dated 11/26/2024, the Care Plan indicated the resident had moderate risk for falls. The care plan indicated the environment should be adapted to meet the resident's safety needs. During a record review of Resident 44's Fall Risk Assessment, dated 2/6/2026, it indicated Resident 44 was assessed to be at moderate risk for fall. During an observation on 3/31/2026 at 9:55 AM in Resident 44's room, a black synthetic gait belt, approximately 5 ft. long, was observed on the floor near Resident 44's bed. During a concurrent observation and interview on 3/31/2026 at 10 AM with the Licensed Vocational Nurse (LVN 3), in Resident 44's room, LVN 3 stated the black gait belt was on the floor near Resident 44's bed. (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

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	04/03/2026

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 4/2/2026 at 2:54 PM with Restorative Nurse Assistant (RNA 1), RNA 1 stated RNA 1 forgot the black synthetic gait belt on the floor. RNA 1 stated, sorry about that. The resident might fall. I will not do it again. RNA 1 also stated the black synthetic gait belt was approximately 5 ft. long and it is an accident hard for the resident since the resident my trip and fall. During a concurrent interview and record review on 4/3/2026 at 1:36 PM with the Director of Nursing (DON), the facility's Policy and Procedures (P&P) titled Fall Management Program, dated 11/1/2017 was reviewed. The DON stated the P&P indicated that it is the policy of the facility to provide the highest quality care in the safest environment for the residents residing in the facility. The DON stated the P&P also indicated to keep walkway obstruction and spill free. The DON also stated the facility must remain clutter free to prevent accidents. 2. During a review of Resident 9's admission Record, the admission Record indicated the resident was admitted to the facility on [DATE] with diagnosis that included difficulty in walking and history of fall. During a review of Resident 9's MDS, dated [DATE], the MDS indicated Resident 9 had severe impairment in cognitive skills for daily decision making. The MDS also indicated Resident 9 was dependent (helper does all the effort) with toileting, shower, lower body dressing and putting on/taking off footwear. The MDS further indicated Resident 9 required substantial/maximal assistance with oral hygiene and upper body dressing. During an observation in the resident's room on 4/1/2026 at 9:30 AM, Resident 9 was observed sitting in her wheelchair with the resident's feet dangling and were far away from the wheelchair's footrest with Certified Nursing Assistant 2 (CNA 2) watching the resident. During an observation on 4/1/2026 at 9:40 AM, Resident 9 was seen being wheeled by CNA 2 out in the hallway with the resident's feet still dangling and not resting on the wheelchair's footrest. During an interview on 4/1/2026 at 2:28 PM, Occupational Therapist (OT) stated Resident 9's feet should not be hanging while sitting on the wheelchair and should be on the footrest to prevent leg spasm. The OT also stated Resident 9's footrest should be adjusted to the resident's height and foot distance to the footrest. During an interview on 4/2/2026 at 2:53 PM, the DON stated Resident 9's wheelchair was too high for the resident and Rehabilitation Department (RD) should have evaluated Resident 9's for right and appropriate wheelchair height to prevent the resident's feet from dangling off the floor or the footrest of the wheelchair. The DON also stated Resident 9's feet should not be dangling for proper body alignment and to prevent the resident from falling which could result in injuries while the resident is sitting in the wheelchair. During a review of the facility's P&P titled, Positioning and Body Alignment, revised 11/1/2017, the P&P indicated that the residents' legs are positioned with feet placed firmly on the floor or wheelchair (continued on next page)

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	04/03/2026

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	footrest when in a sitting position. The P&P also indicated when positioning the resident on a wheelchair that the footrest is adjusted so that the resident's thighs are parallel with supporting surface. 3. During a concurrent observation and interview on 4/2/2026 at 1:58 PM, the Hoyer Lift was parked in the hallway unplugged and with the base wide open. CNA 3 stated they always park the Hoyer lift in the hallway and that was where they are being charged. CNA 3 also stated the staff were not using the Hoyer lift right now but the facility does not have a storage area to place them. During an interview on 4/2/2026 at 2:06 PM, RNA 2 stated the base of the Hoyer lift should be closed and not left open because anyone can trip and have a fall accident if the base was left open. RNA 2 also stated they leave the Hoyer lift at the hallway because they do not have a storage area to put them in. During an interview on 4/2/2026 at 3:08 PM, the DON stated the facility staff should have placed the Hoyer lift in the area where there was no traffic and residents and staff do not frequently pass by. The DON also stated the facility normally keeps the Hoyer lift in the hallway while it is being charged but the base of the Hoyer lift should be closed to prevent staff and residents from trip and fall accidents. The DON further stated Hoyer lift could pose an accident hazard if the base was left open. During a review of the facility's P&P titled, Resident Rooms and Environment, revised 11/1/2017, the P&P indicated that the facility was to provide residents with a safe, clean, and comfortable and homelike environment. The P&P also indicated that the facility was to ensure the resident could receive care and services safely and that the physical layout of the facility maximizes residents' independence and does not pose a safety risk. 4. During an observation and interview on 4/3/2026 at 1:32 PM, the facility's laundry room had two washers (Washer 1 and 2) and two dryers (Dryers 1 and 2). Laundry Staff (LS) stated she did not know how to open the dryer's front compartment. LS called the Maintenance Supervisor (MS) for assistance and at 1:42 PM, MS came into laundry and opened the Dryers 1 and 2's compartment. MS and LS observed a thick layer of lint around an internal compartment located between the lint screens and the lint vent of Dryer 1 and 2's lint. LS proceeded to remove the lint from the lint trap screen and sweep the internal compartment's bottom surface. MS stated the laundry staff last cleaned the lint compartment was around 6 AM. MS stated the lint present in this internal compartment was a fire hazard and it should have been cleaned ever two (2) hours. During an interview on 4/3/2026 at 1:50 PM with LS, LS stated she had not removed the dryer lint from Dryer 1 and 2 at 8 AM, 10 AM, and 12 PM. LS stated the lint compartment was supposed to be cleaned every 2 hours. During a record review on 4/3/2026 at 1:57 PM with the LS, the facility's Dryer Lint Cleaning Log (DLCL) was reviewed. DLCL indicated Dryers 1 and 2 shall be cleaned every two hours and staff must write the initials at the date and time when the lint traps have been cleaned. DLCL was blank on 4/3/2026 at 8 AM, 10 AM, and 12 PM. (continued on next page)

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	04/03/2026

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the facility's policy and procedure titled, Interior Maintenance Laundry Room/ Water Temperature, effective 1/1/1999, indicated maintenance of the clothes dryer included to check that the laundry personnel were cleaning filters every two hours, vacuum areas around filters, and to make sure equipment was free of lint.

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	04/03/2026

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record review, the facility failed to maintain the food service area in a clean and sanitary condition and failed to follow its proper food - handling policy procedure by failing to ensure: A container of lentils was properly covered with a lid.The can opener was sanitized and free of dry food residue. These deficient practices have the potential to result in pathogen (germ) exposure to residents, which could place the residents at risk for developing foodborne illness ([food poisoning] with symptoms including upset stomach, stomach cramps, nausea, vomiting, diarrhea, and fever) and can lead to other serious medical complications and hospitalization.Findings: During a concurrent kitchen observation and interview on 3/31/2026 at 12:46 PM, with the Dietary Supervisor (DSS 1), DSS 1 stated that the clear container of lentils did not have its lid properly closed. During a concurrent observation in the kitchen and interview on 4/1/2026 at 8:18 AM with the Dietary Supervisor (DDS 2), DSS 2 stated that the can opener contained dry food residue, including a white unknown residue and brown- black gunk (an accumulation of greasy or dirty buildup commonly found on dishes, in sinks, or kitchen appliances). During an interview on 4/2/2026 at 12:44 PM with Dietary Aide (DA 1), DA 1 stated all containers should be properly closed to prevent insects and dust from entering, as these can contaminate food and potentially cause illness. During an interview on 4/2/2026 at 12:45 PM, DA 1 also stated that the can opener should be cleaned after each use. During a concurrent interview and record review on 4/2/2026 at 3:27 PM with the DSS2, the facility's P&P titled Food Storage, revised on 11/1/2017, was reviewed. DSS 2 stated the P&P indicated that Any open products should be placed in storage container with tight fitting lid. DSS2 stated they did not follow the P&P for food storage. During a concurrent interview and record review on 4/2/2026 at 3:30 PM with the DSS 2, the facility's P&P titled, Can Opener Use and Cleaning, revised date 11/1/2017 was reviewed. DSS 2 stated the P&P indicated the can opener will be sanitized between uses. DSS 2 stated the P&P for food storage and can opener sanitation was not followed. DSS 2 also stated that failure to sanitize the can opener between uses, and not closing container lids properly, can lead to food contamination and has the potential to cause illnesses such as stomachache and diarrhea.

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	04/03/2026

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 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to maintain safe, clean, comfortable sanitary and home-like environment for two (2) of five (5) sampled residents (Resident 11 and 18) reviewed for environment by failing to:Ensure Resident 11's bedside rails (safety devices or barriers attached to the sides of a bed to prevent falls, assist with repositioning, and provide support for getting in and out of bed) foam padding was in good condition. The facility failed to ensure two wash basins and three hand towels were not placed in the toilet tank in Resident 18 ?s restroom. These deficient practices caused an unsanitary and had potential for residents to be placed at risk for serious illness and/ or injury.Findings: 1.During a review of Resident 11's admission Record, the admission Record indicated the resident was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses of acute respiratory failure (an inability to maintain adequate oxygenation for tissues or adequate removal of carbon dioxide from tissues) and type 2 diabetes mellitus (a disease that occurs when there is a problem in the way the body regulates and uses sugar as fuel). During a review of Resident 11'S Minimum Data Set (MDS – a resident assessment tool), dated 3/19/2026 the MDS indicated the resident was assessed to have severe impairment with cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decision making. The MDS also indicated Resident 11 needed partial moderate assistance (helper does less than half the effort) on eating, oral hygiene (the ability to use suitable items to clean teeth) and substantial maximal assistance (helper does more than half the effort) on sit to lying (the ability to move from sitting on the bed to lying flat on the bed). During a record review of Resident 11's Order Summary Report dated 4/1/2026, the order summary report indicated an order for quarter bedside rails up times two (two half bedside rails up [head of bed]) as an enabler to promote bed mobility, functional mobility and transfer, with an order date of 8/26/2025. During an observation on 3/31/2026 at 9:21 AM in Resident 11's room, Resident 11's black foam padding on the left bedside rails was damaged, with multiple tears visible and a section ripped off in the middle. During a concurrent observation and interview on 4/1/2026 at 2:05 PM with the Environmental Services (EVS 1) in Resident 11's room, EVS 1 stated the black foam padding attached to the left bedside rails was damaged and falling apart. EVS1 stated, when the foam padding shows wear and tear, it should have been replaced. During an interview on 4/1/2026 at 2:16 PM with the License Vocational Nurse (LVN 1), LVN 1 stated the black foam padding on the resident's bedside rails are required to be in good condition to ensure residents' protection, and that foam padding that is falling apart from the bedside rails could potentially cause harm or injury to a resident. During a concurrent interview and record review on 4/3/2026 at 1:39 PM with the Director of Nursing (DON), the facility's Policy and Procedures (P&P) titled Resident Rooms and Environment dated 11/1/2017 was reviewed. The DON stated the facility's P&P indicated, it is the policy of the facility to (continued on next page)

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	04/03/2026

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 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	provide residents with a safe, clean, comfortable and homelike environment. The DON also stated that the black foam padding on the bedside rails of Resident 11 that was falling apart was not acceptable. The DON stated, it was not safe, comfortable and not giving the resident a homelike environment, and the facility's P&P was not followed. 2. During a review of Resident 18's admission Record, the admission Record indicated the resident was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnosis that included chronic kidney disease (gradual loss of kidney damage where kidneys cannot filter the blood the way they should), history of falling, and bradycardia (a low heart rate, when resting heart rate below 60 beats per minute). During a review of Resident 18's Minimum Data Set (MDS- a resident assessment tool), dated 3/16/2026, the MDS indicated Resident 18 had severe impairment in cognitive skills for daily decision making. The MDS also indicated Resident 18 was dependent (helper does all the effort) with toileting and required partial/moderate assistance with eating, oral hygiene, and putting on/taking off footwear. During an observation on 4/3/2026 at 11:12 AM in the Resident 18's room. CNA 3 was observed placing two (2) wash basins and three (3) hand towels over the toilet tank and walking out of the restroom. CNA 3 stated the wash basins and hand towels were used to provide morning care for Resident 18 and should never be placed on the toilet tank. CNA 3 stated the toilet tank should not be considered as a clean surface for placing morning care supplies. During an interview on 4/3/2026 at 3:03 PM with Infection Preventive Nurse (IPN), IPN stated putting wash basins and towels over the toilet tank were unsanitized because during toilet flushing, aerosolized particles would spew into the air and contaminate the wash basins and towels with bacteria.

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	04/03/2026

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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure the call light (a communication device in hospitals and nursing homes that allows patients to alert staff for assistance) was within arm's reach for one (1) of four (4) sampled residents (Resident 7) reviewed for environment in accordance with the facility's policy and procedure (P&P) titled, Communication - Call System: This deficient practice had the potential for Resident 7 not to be able to call the facility staff for help or assistance, especially during an emergency.Findings:During a review of Resident 7's admission Record, the admission Record indicated the resident was admitted to the facility on [DATE] with diagnosis that included dementia (loss of memory, language, problem-solving and other thinking abilities that are severe enough to interfere with daily life), type 2 diabetes mellitus (a condition in which the body cannot regulate blood sugar levels in the blood), and difficulty in walking. During a review of Resident 7's Minimum Data Set (MDS- a resident assessment tool), dated 3/3/2026, the MDS indicated Resident 7 had moderate impairment in cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decision making. The MDS also indicated Resident 7 required substantial/maximal assistance (helper does more than half the effort) with eating and was dependent (helper does all the effort) with oral hygiene, toileting hygiene, lower body dressing and putting on/taking off footwear. During an observation and interview on 3/31/2026 at 8:41 AM with Resident 7 in the room, Resident 7 ?s call light was under the mattress behind the resident's bed. Resident 7 stated she did not know where the call light was. During an interview on 4/1/2026 at 01:21 PM, Certified Nursing Assistant 1 (CNA 1) stated call light was not within Resident 7 reach, and the resident will not be able to use the call light to alert the staff when the resident needed help. During an interview on 4/3/2026 at 4:06 PM, the Director of Nursing (DON) stated the call lights should be within reach of the resident so the resident can use it to call for help and get assistance if desired. During a review of the facility's P&P titled, Communication - Call System, revised 11/1/2017, the policy indicated that the facility provides a mechanism for residents to promptly communicate with nursing staff. The policy also indicated the call cords (call light) will be placed within the resident's reach in the resident's room.

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	04/03/2026

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 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to secure the residents personal and medical records when the facility did not destroy identifiable information on the resident's discarded oxygen humidifier (bottle device attached to an oxygen concentrator [a medical device that provides supplemental oxygen to people with breathing disorders], tank, or liquid system to add moisture to dry medical oxygen, reducing nasal dryness, nosebleeds, and throat irritation) container for one (1) of 17 sampled residents (Resident 6). This deficient practice has the potential for unauthorized release of resident's personal information.Findings: During a review of Resident 6's admission Record, the admission Record indicated the resident was admitted to the facility on [DATE] with diagnosis that included bipolar disorder (sometimes called manic-depressive disorder; mood swings that range from the lows of depression to elevated periods of emotional highs), depression (a common and serious medical illness that negatively affects how the person feels, the way they think and how they act), and type two (2) diabetes mellitus (a condition in which the body cannot regulate blood sugar levels in the blood). During a review of Resident 6's Minimum Data Set (MDS- a resident assessment tool), dated 3/9/2026, the MDS indicated Resident 6 had moderate impairment in cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decision making. The MDS also indicated Resident 6 required substantial/maximal assistance (helper does more than half the effort) with eating and was dependent (helper does all the effort) with oral hygiene, toileting hygiene, lower body dressing and putting on/ taking off footwear. During an observation on 3/31/2026 at 8:01 AM in Resident 6's room, an oxygen humidifier container was labeled with resident's full name and room number was found inside the trash bin in the resident's room. During a concurrent observation on 3/31/2026 at 8:13 AM in Resident 6's room with the Infection Prevention Nurse (IPN), IPN confirmed that the oxygen humidifier container labeled with Resident 6's full name and room number was in the trash bin. IPN stated the resident's identifiable information must be destroyed before discarding in the trash bin. During an interview on 4/1/2026 2:17 PM with Director of Staff Development (DSD), DSD stated with the resident's identifiable information must be removed before throwing any medical equipment or supply in a regular trash bin, and that is in accordance with Health Insurance Portability Accountability Act (HIPAA, a law designed to provide privacy standards to protect patient's medical record and other health information) law. The DSD also stated, Resident 1's oxygen humidifier found inside the trash bin clearly showed identifiable resident's information. DSD stated resident information should not be visible to unauthorized individuals. During a review of the facility's admission Packet (information given to each resident admitted into the facility) includes Resident [NAME] of Rights dated May 2011, indicated the resident has the right to personal privacy and confidentiality of his or her personal clinical records. During a review of the facility's policy and procedure (P&P) titled Privacy and Dignity, dated 11/1/2017. The P&P indicated rights to privacy are a part of the admission agreement and the resident is informed of these rights during the admission process which includes residents are afforded a right to privacy and confidentiality. The P&P also indicated resident rights to privacy and confidentiality of medical information and the clinical record is provided upon admission and explained to the resident during the admission process.

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	04/03/2026

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 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, and record review, the facility failed to complete a Preadmission Screening and Resident Review (PASRR, a federal requirement to help ensure that every resident entering a Medicaid Certified Nursing Facility [NF] receives a Level I screening and if necessary a Level II Evaluation to ensure that the NF residence is appropriate and to identify what specialized services the resident may need) for one (1) of three (3) sampled residents (Resident 10) reviewed for PASRR care area, in accordance with the facility's policy. This deficient practice had the potential to result in inappropriate placement of Resident 10 and had the potential for the resident not to receive the necessary care and services the resident needs. Findings:During a review of Resident 10's admission Record, the admission Record indicated Resident 10 was initially admitted to the facility on [DATE] and was readmitted on [DATE] with diagnoses that included depression (a mood disorder that causes a persistent feeling of sadness and loss of interest), schizophrenia (a mental illness that is characterized by disturbances in thought), and psychosis (a severe mental condition in which thought, and emotions are so affected that contact is lost with reality). During a review of Resident 10's Minimum Data Set (MDS- a resident assessment tool), dated 1/27/2026, the MDS indicated Resident 10 had moderate impairment in cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decision making. The MDS also indicated Resident 10 required partial/moderate assistance (helper does less than half the effort) with toileting hygiene and shower and required supervision (helper provides cues) with eating, oral and personal hygiene, upper and lower body dressing, and putting on/taking off footwear. The MDS further indicated Resident 10 has an active diagnosis of depression, psychotic disorder, and schizophrenia. During a review of Resident 10's Medical Records, Residents 10's Medical Records did not indicate that there was a PASARR 1 screening on 11/23/2025 re-admission. Resident 10's medical records indicated a positive PASARR 1 screening on 8/4/2023 and was unable to complete level 2 evaluation on 8/8/2023 as it indicated the resident has no serious mental illness. Resident 10's medical records indicated a diagnosis of depression on 7/21/2025 and 10/28/2025 as indicated on MDS. During a concurrent interview and review of Resident 10's Electronic Medical Record (EMR, an electronic version of the resident's medical history that is maintained by the provider over time) on 4/2/2026 at 12:24 PM with the MDS coordinator, the MDS coordinator stated Resident 10's EMR did not have PASARR level 1 screening from the hospital where the resident was transferred from. The MDS coordinator also stated there should be a PASSAR level 1 screening to check if Resident 10 has mental illness and coordinated with the state agency for further evaluation and proper placement of the resident if the screening is positive. During an interview on 4/2/2026 at 3:00 PM, the Director of Nursing (DON) stated resident 10's PASSAR level 1 screening should have been done if there was none completed at the hospital upon the resident's readmission to ensure the resident was being placed appropriately. During a review of the facility's Policy and Procedure (P&P) titled, Preadmission Screening and Resident Review Reports (PASRR), revised 7/1/2023, the P&P indicated that the facility must ensure that PASARR level 1 is completed either by the transferring general acute care hospital (GACH) or by the facility for all applicants, regardless of payor, prior to admission to determine if they have serious mental illness and/or intellectual disability, developmental disability or related conditions.

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	04/03/2026

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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure the low air loss mattress (LAL mattress, a specialized medical bed mattress designed to prevent and treat pressure ulcers [localized damage to the skin and/or underlying tissue usually over a bony prominence] by constantly blowing a tiny amount of air through small holes in its surface) was at a correct setting for one (1) of two (2) residents (Resident 21) reviewed for pressure ulcer , in accordance with the facility's policy and procedure. This deficient practice placed Residents 21 at risk for development of new pressure ulcers and prevent healing of the resident's existing Stage 4 pressure ulcer (full-thickness skin and tissue loss with exposed muscle, tendon, ligament, cartilage, or bone) on the sacrococcyx (pertains to both large triangular shaped bone in the lower spine that forms part of the pelvis and the tailbone).Findings: During a review of Resident 21's admission Record, the admission Record indicated the resident was admitted to the facility on [DATE] with diagnosis that included pressure ulcer (refers to localized damage to the skin and/or underlying soft tissue usually over a bony prominence or related to a medical or other device). During a review of Resident 21's Minimum Data Set (MDS- a resident assessment tool), dated 1/16/2026, the MDS indicated Resident 21 had severe impairment in cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decision making. The MDS also indicated Resident 21 was dependent (helper does all the effort) with toileting and required partial/moderate assistance (helper does less than half the effort) with oral hygiene, shower, lower body dressing and putting on/taking off footwear. The MDS further indicated Resident 21 required supervision (helper provides cues) with eating, upper body dressing and personal hygiene. During a review of the Physician's Order, dated 1/15/2026, at 1:38 PM, the Physician's Order indicated use of LAL mattress for skin maintenance treatment with instructions to check for setting and functionality. During a review of Resident 21's Care Plan, dated 1/16/2026, the Care Plan indicated the resident has LAL for wound management with setting range of 150 to 160 pounds to minimize the risk of further tissue breakdown and a proposed plan to keep LAL mattress on the correct setting according to the resident's weight and comfort. During a review of Resident 1's Wound Weekly Observation Tool (a structured, standardized documentation form used by healthcare professionals to measure, and track the healing progress of pressure injuries, ulcers or surgical sites at least once a week), dated 3/18/2026, the Wound Weekly Observation Tool indicated a wound assessment to the Sacro-coccyx stage 4 pressure injury, measuring 2.2 centimeters (cm, unit of measurement) by 1.22 cm by 1 cm (length and width) and a tunneling depth of 2.4 cm. During an observation on 4/1/2026 at 10:23 AM, Resident 21 was lying in bed with the LAL set at 180 pounds. Resident 21 stated she weighs around 150 pounds. During a concurrent interview and review of Resident 21's Electronic Medical Record (EMR, an electronic version of the resident's medical history that is maintained by the provider over time) on 4/2/2026 at 8:08 AM, Licensed Vocational Nurse 2 (LVN 2) stated Resident 21's weight in the EMR was 158 pounds. During a concurrent observation, interview on 4/2/2026 at 8:12 AM, LVN 2 stated Resident 21's LAL setting was set at 180 pounds. LVN 2 also stated Resident 21's LAL setting should be based on the resident's current weight and not at 180 pounds to prevent creating pressure on the resident's sacral area where she had pressure injury and to promote wound healing. During an interview on 4/2/2026 at 3:01 PM, the Director of Nursing (DON) stated LAL was used to prevent further development of pressure injuries and help with the healing of pressure injuries. The DON also stated the LAL mattress should be set based on the weight of Resident 21 to prevent development of another pressure injuries. During a review of the facility's Policy and Procedure (P&P) titled, Wound Management, revised 11/1/2017 indicated that the facility provides a system for the treatment and management of residents with wounds including pressure and non-pressure ulcers. The P&P also indicated that a resident who has a wound will receive necessary treatment and services to promote healing, prevent infection, and prevent new (continued on next page)

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	04/03/2026

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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	pressure ulcers from developing. During a review of the facility's P&P titled, Pressure Reducing Mattress, dated 4/2022 indicated that a specialty mattress which included the LAL mattress or bed will be obtained for pressure relief of residents that have pressure injury or at risk for pressure injury. The P&P also indicated for setting the pressure reducing mattress according to resident's height and weight, to consider referring to manufacturer's guidance.

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	04/03/2026

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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure the oxygen via nasal cannula (NC, a medical device used to provide supplemental oxygen therapy to people who have lower oxygen levels) was administered for one (1) of three (3) sampled residents (Resident 66) reviewed for respiratory services in accordance with the facility's policy. This deficient practice had the potential for Resident 66 not being able to receive the benefits of the supplemental oxygen ordered and had the potential to compromise the resident's respiratory function which could lead to complications. Findings: During a review of Resident 66's admission Record, the admission Record indicated the resident was initially admitted to the facility on [DATE] and was readmitted on [DATE] with diagnoses that included chronic obstructive pulmonary disease (COPD-a chronic lung disease causing difficulty in breathing) and pulmonary edema (the buildup of excess fluid in the lungs air sacs making it hard to breath). During a review of Resident 66's Minimum Data Set (MDS- a resident assessment tool), dated 1/19/2026, the MDS indicated Resident 66 had moderate impairment in cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decision making. The MDS also indicated Resident 66 required substantial/maximal assistance (helper does more than half the effort) with shower and required partial/moderate assistance (helper does less than half the effort) with oral, toileting and personal hygiene, upper and lower body dressing and putting and taking off footwear. The MDS further indicated Resident 66 required supervision (helper provides cues) with eating. During a review of Resident 66's Care Plan initiated on 5/2/2025 and revised on 5/12/2025, the Care Plan indicated the resident has impaired gas exchange related to increased oxygen demand with a goal to improve the resident's oxygenation and an approach plan to administer oxygen as ordered. During a review of Resident 66's physicians order dated 3/6/2026 at 2:44 PM, the physicians order indicated they may provide Resident 66 with supplemental oxygen at 2 liter per minute (LPM - unit of flow rate) via NC as needed (prn). The physician's order also indicated may titrate (to slowly and carefully adjust until desired result is achieved) 5 LPM to keep oxygen saturation above 90 percent as needed. During an observation on 3/31/2026 at 9:44 AM, Resident 66 was lying in bed with oxygen at 2 LPM and NC prongs not in the resident's nose but were seen on the left side of the resident's face. CNA (unable to get the name) who entered the room after being called by the surveyor confirmed that Resident 66's NC was not correctly placed in the resident's nose. During an interview on 4/2/2026 at 3:39 PM, Licensed Vocational Nurse 4 (LVN 4) stated Resident 66's NC prong should be in the resident's nostril so that the resident would get the benefit of receiving oxygen. During an interview on 4/3/2026 at 7:47 AM, LVN 1 stated Resident 66 would not be getting the oxygen ordered if the NC prong was not correctly placed in the resident's nose. LVN 1 also stated Resident 66 could develop shortness of breath (SOB, difficulty breathing) and desaturate (low blood oxygen level) if the resident is not getting the ordered oxygen. During an interview on 4/3/2026 at 7:51 AM, the Director of Nursing (DON) stated Resident 66's breathing could get affected and the resident desaturate if the oxygen NC prongs were not correctly placed in the resident's nose. During a review of the facility's Policy and Procedure (P&P) titled, Oxygen Administration, revised 11/1/2017, the P&P indicated its purpose was to prevent or reverse hypoxemia (abnormally low level of oxygen in the blood) and provide oxygen to the tissues. The P&P also indicated that the facility was to check that the oxygen is flowing through the tubing and placed the NC prongs into the nares (nose) and adjust plastic slide under the chin until the nasal cannula fits snugly.

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	04/03/2026

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 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Dispose of garbage and refuse properly. Based on observation, interview, and record review, the facility failed to ensure one (1) of two (2) dumpsters (a movable waste container) were closed and not overflowing, in accordance with the facility's Garbage and Trashcan Use and Cleaning Policy and Procedure (P&P). This deficient practice had a potential to attract vermin (animals that are believed to be harmful, carry diseases such as rodents, parasitic worms, or insects), pests (any living thing that has a negative effect on humans), and wildlife (undomesticated animal species), increasing the risk of disease transmission and health issues for residents, staff, and the surrounding community.Findings: During a concurrent observation and interview on 3/31/20226 at 8:05 AM with the Dietary Supervisor (DSS1) in the facility parking lot, DSS1 stated that 1 dumpster was overflowing with trash, emitted a foul odor, and had its lid left open. During an interview on 4/2/2026 at 12:44 PM, Dietary Aide (DA 1) stated that dumpsters should not overflow to prevent odors and the attraction of rodents and insects, which could potentially cause illnesses such as stomachache and diarrhea. During a concurrent interview and record review on 4/2/2026 at 3:27 PM with the DSS 2, the facility's P&P titled, Garbage and Trash Can Use and Cleaning, revised11/1/2027 was reviewed. DSS1 stated the P&P requires that food waste be placed in covered garbage and trash cans.

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	04/03/2026

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review, the facility failed to maintain a complete and accurate medical records for three (3) of 17 sampled residents (Residents 12, 21, and 9) in accordance with the facility's Charting and Documentation policy and procedure (P&P) by failing to ensure: 1. Resident 21's sacro-coccyx (pertains to both large triangular shaped bone in the lower spine that forms part of the pelvis and the tailbone) wound care treatment in the Treatment Administration Record (TAR) on 3/15/26, 3/16/2026 and 3/17/2026.2. Resident 9's physician order for Seroquel (drug used to treat schizophrenia) included an indication for use.3. Resident 12's pneumonia (an infection that inflames the air sacs (alveoli) in one or both lungs, causing them to fill with fluid or pus) vaccine consent and Covid-19 (a severe respiratory illness caused by virus and spread from person to person) vaccine consent form included Resident 12's signature.This deficient practice resulted in the medical records inaccurate representation of care provided to Residents 12, 21, and 9 and had the potential to result in delayed communication between care teams.Findings: 1. During a review of Resident 21's admission Record, the admission Record indicated the resident was admitted to the facility on [DATE] with diagnosis that included pressure ulcer (refers to localized damage to the skin and/or underlying soft tissue usually over a bony prominence or related to a medical or other device). During a review of Resident 21's Minimum Data Set (MDS- a resident assessment tool), dated 1/16/2026, the MDS indicated Resident 21 had severe impairment in cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decision making. The MDS also indicated Resident 21 was dependent (helper does all the effort) with toileting and required partial/moderate assistance (helper does less than half the effort) with oral hygiene, shower, lower body dressing and putting on/taking off footwear. The MDS further indicated Resident 21 required supervision (helper provides cues) with eating, upper body dressing and personal hygiene. During a concurrent interview and record review on 4/2/2026 at 3:22 PM with Treatment Nurse 1 (TN 1), Resident 21's TAR for the month of March 2026 was reviewed. The TAR indicated a wound treatment for Resident 21's Sacro-coccyx pressure injury with normal saline (NS-a saltwater solution), apply collagen powder (a wound dressing that can be used to treat a variety of wounds), and pack loosely with iodoform (compound used as wound dressing to prevent infection) 1/4 packing strips, then cover with super absorbent dressing daily. TN 1 stated the wound treatment for 3/15/2026, 3/16/2026, and 3/17/2026 were provided to Resident 21 but it was not reflected on the TAR. TN 1 stated the TAR should have been signed after giving the wound treatment. During an interview on 4/2/2026 at 3:34 PM, Licensed Vocational Nurse 4 (LVN 4) stated Resident 21's wound treatment should be consistent and followed according to the doctor's order to prevent the wound from getting worse and documented as evidence the wound care was provided. LVN 4 also stated the wound treatment should be documented to help track the healing progress of Resident 21's pressure ulcer. During an interview on 4/2/2026 at 3:46 PM, LVN 2 stated she was doing the wound treatment for Resident 21 on 3/17/2026 but forgot to sign the TAR. LVN 2 also stated Resident 21's TAR did not (continued on next page)

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	04/03/2026

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	have accurate documentation of the wound treatments provided and should be accurate to ensure the wound treatments were being communicated to other TNs. During an interview on 4/2/2026 at 3:54 PM, Registered Nurse 1 (RN 1) stated she provided the wound care treatment for Resident 21 on 3/15/2026 and 3/16/2026 but should have made sure it was documented in the TAR. RN 1 also stated Resident 21's TAR was not accurate and wound treatments provided should be documented to prove and validate treatments were done. 2. During a review of Resident 9's admission Record, the admission Record indicated the resident was admitted to the facility on [DATE] and readmitted on [DATE], with diagnosis that included psychosis (a severe mental condition in which thought, and emotions are so affected that contact is lost with reality) and dementia (a progressive state of decline in mental abilities). During a review of Resident 9's MDS, dated [DATE], the MDS indicated Resident 9 had severe impairment in cognitive skills for daily decision making. The MDS also indicated Resident 9 was dependent on toileting, showering, lower body dressing and putting on/taking off footwear. The MDS further indicated Resident 9 required substantial/maximal assistance with oral hygiene and upper body dressing and required partial/moderate assistance (helper does less than half the effort) with eating. During a review of Resident 9's Physician's Order, dated 3/10/2026, the Physician's Order indicated Seroquel 25 milligrams (mg, units of measurement) twice a day. During a concurrent interview and record review on 4/3/2026 at 9:41 AM, with the Director of Nursing (DON), Resident 9's medication reconciliation from General Acute Care Hospital (GACH) dated 3/10/2026, the physician's order and psychiatrist notes were reviewed. The DON stated Resident 9's Psychiatrist notes indicated Resident 9 has a diagnosis of psychosis. The DON stated Resident 9's Physician's Order was incomplete since it should have included a diagnosis for the use of Seroquel. The DON stated this should have been clarified with the Psychiatrist to ensure the medication is appropriate for the resident. During an interview on 4/3/2026 at 11:03 AM, RN 1 stated the Seroquel order should be clarified with the psychiatrist if it did not have an indication on the medication order to ensure the medication is being used for the right diagnosis. During a review of the facility's P&P titled, Psychotherapeutic Drug Management, revised 1/5/2026, the P&P indicated Attending Physician/Licensed Healthcare Professional responsibility was to ensure the psychotherapeutic medication order will include the indications and manifestations of the disorder treated. 3.During a review of Resident 12's admission Record, the admission Record indicated the resident was admitted to the facility on [DATE] with diagnosis that included chest pain, lack of coordination, and pain in bilateral knees. During a review of Resident 12's MDS, dated [DATE], the MDS indicated Resident 12 had mild impairment in cognitive skills for daily decision making. During a concurrent interview on 4/3/2026 at 11:12 AM with Resident 12, Resident 12 stated Infection Prevention Nurse (IPN) offered her pneumonia vaccine and covid-19 vaccine, however, IPN did not (continued on next page)

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	04/03/2026

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	asked her to sign any consent. During a concurrent interview and record review on 4/3/2026 at 3:03 PM with IPN, Resident 12's pneumonia vaccine consent and Covid-19 vaccine consent forms were reviewed. IPN stated vaccines were offered to Resident 12 on 1/3/2026, however, the consent forms were not signed. IPN stated consent forms should be signed after offering the vaccines. IPN stated this was important for accurate tracking of vaccine in case recall occurs and reduced duplicate vaccination. During a review of the facility's P&P titled, Informed Consent, revised 1/5/2026, the P&P indicated the informed consent must be signed by the resident or the resident's representative and the physician who provided the material information. i. copies of the signed informed consent form shall be given to the resident or the resident's representative. ii. residents who are conserved but retain the legal power to consent or refuse will be informed and asked for consent. During a review of the facility's P&P titled, Documentation - Nursing, revised 11/1/2017, the P&P indicated its purpose was to provide documentation of residents' status and care given by nursing staff. The P&P also indicated that nursing documentation will be concise, clear, pertinent, and accurate.

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	04/03/2026

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 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that a working call system is available in each resident's bathroom and bathing area. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure the call light was within resident's arm's reach for one (1) of five (5) sampled residents (Resident 21) reviewed for environment in accordance with the facility's policy. This deficient practice had the potential for Resident 21 not to be able to call the facility staff for help or assistance, especially during an emergency.Findings: During a review of Resident 21's admission Record, the admission Record indicated the resident was admitted to the facility on [DATE] with diagnosis that included anxiety disorder (a mental health disorder characterized by feeling of worry, or fear that are strong enough to interfere with one's daily activities) and bipolar disorder (sometimes called manic-depressive disorder; mood swings that range from the lows of depression to elevated periods of emotional highs). During a review of Resident 21's Minimum Data Set (MDS- a resident assessment tool), dated 1/16/2026, the MDS indicated Resident 21 had severe impairment in cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decision making. The MDS also indicated Resident 21 was dependent (helper does all the effort) with toileting and required partial/moderate assistance (helper does less than half the effort) with oral hygiene, shower, lower body dressing and putting on/taking off footwear. The MDS further indicated Resident 21 required supervision (helper provides cues) with eating, upper body dressing and personal hygiene. During an observation on 3/31/2026 at 8:38 AM, Resident 21 was in bed sleeping. Resident 21's call light was observed out of reach, located at the back of the bed and on the floor. During an interview on 4/2/2026 at 10:13 AM, Licensed Vocational Nurse 1 (LVN 1) stated call lights should be within the residents' arms reach so they can use them to call whenever they needed help. During an interview on 4/2/2026 at 3:06 PM, the Director of Nursing (DON) stated the call light should be within reach of Resident 21 so she could use it when she needs assistance or has concerns that require attention. During a review of the facility's Policy and Procedure (P&P) titled, Communication - Call System, revised 11/1/2017, the P&P indicated that the facility provides a mechanism for residents to promptly communicate with nursing staff. The policy also indicated the call cords will be placed within the resident's reach in the resident's room.

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	04/03/2026

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 0732 Level of Harm - Potential for minimal harm Residents Affected - Some	Post nurse staffing information every day. Based on interview and record review, the facility failed to ensure the Daily Staffing Report (Nurse Staffing Information) posted on 3/31/2026 and 4/2/2026 was accurate by failing to reflect the correct total number and actual hours of licensed nursing staff directly responsible for resident care, in accordance with the facility's policy and procedure (P&P). This deficient practice had the potential to misinform residents, families, and the public regarding the actual nursing staff providing direct care to the residents.Findings: During a review of the Daily Staffing Report posted for 3/31/2026, the Daily Staffing Report indicated a census of 65 and zero (0) number of Registered Nurse (RN) for day shift. During a review of the Facility Staffing Assignment for 3/31/2026, the Facility Staffing Assignment indicated the facility had a total of three (3) RNs (as opposed to 0 RN listed on the Daily Staffing Report) for day shift. During a review of the Daily Staffing Report, the Daily Staffing Report posted for 4/2/2026 indicated a census of 65 and a total number of 0 RN and 3 Licensed Vocational Nurses (LVNs) for day shift, and one (1) RN and two (2) LVNs for evening shift. During a review of the Facility Staffing Assignment for 4/2/2026, the Facility Staffing Assignment indicated the facility had a total of 2 RNs and 2 LVNs (as opposed to 0 RN and 3 LVNs listed on the Daily Staffing Report) for day shift. The Facility Staffing Assignment also indicated 0 RN and 3 LVNs (as opposed to 1 RN and 2 LVNs on the Daily Staffing Report) for evening shifts. During a concurrent review of the Daily Staffing Report and Facility Staffing Assignment and interview with the Director of Staff Development (DSD) on 4/3/2026 at 11:49 AM, DSD stated the posted Daily Staffing Reports on 3/31/2026 and 4/2/2026 were not accurate because it did not match the Facility Staffing Assignment on 3/31/2026 and 4/2/2026. The DSD also stated the Daily Staffing Report should have been corrected to have an accurate reflection of the Nursing Hours Per Patient Per Day (NHPPD, a staffing measurement used in healthcare facilities, especially longˆterm care, to calculate the average number of nursing care hours provided to each resident in a 24ˆhour period.) During an interview on 4/3/2026 at 1:21 PM, the Director of Nursing (DON) stated the Daily Staffing Report should be accurate to determine if the facility was meeting the required number of staff and the required NHPPD to ensure safe staffing and quality of care. During a review of the facility's P&P titled, Nursing Department - Staffing, Scheduling and Postings, revised 10/24/2022, the P&P indicated its purpose was to ensure an adequate number of nursing personnel are available to meet residents needs. The P&P also indicated that the facility would post daily the total number of licensed and unlicensed nursing staff directly responsible for the resident care per shift which included RNs, LVNs, and Certified Nursing Assistants (CNAs).