

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  056316	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  12/02/2025
NAME OF PROVIDER OR SUPPLIER  Camellia Gardens Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE  1920 N. Fair Oaks Avenue 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 - Few	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public.  (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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<p>F 0921</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observation, interviews and record review, the facility failed to provide a safe environment in accordance with the facility's policy and procedures when: 1. One (1) out of two (2) sample residents (Resident 2) remained in the room with water leaking from the ceiling during the heavy rain. 2. The Hoyer Lift (a mechanical device used to lift and/or transfer a person) was left outside Room A for 6 hours and left a shower chair on the opposite side of the hallway parallel to the Hoyer lift. These deficient practices could potentially result in accidents, injuries and hazard from wet slippery floors, and obstructed hallways compromising the wellbeing of the residents, staff and the visitors. Findings: 1. During a review of Resident 2's admission Record, the admission Record indicated the resident was admitted to the facility on [DATE] with diagnoses that included hypotension (low blood pressure) and anxiety disorder (a mental health disorder characterized by feeling of worry, or fear that are strong enough to interfere with one's daily activities). During a review of Resident 2's Minimum Data Set (MDS- a resident assessment tool), dated 11/14/2025, the MDS indicated Resident 2 had an intact cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decision making. The MDS also indicated Resident 2 was dependent on toileting and personal hygiene, shower, upper and lower body dressing and putting on/taking off footwear and required substantial/maximal assistance (helper does more than half the effort) with eating and oral hygiene. During a review of Resident 2's Care Plan initiated on 11/5/2025, the Care Plan indicated Resident 2 was at risk for falls related to unsteady gait and impaired balance with an approach plan of ensuring resident's risk for falls was assessed and problems identified were addressed. During an interview on 12/2/2025 at 2:38 PM, Infection Prevention Nurse (IPN) stated Resident 2 walks and goes to the bathroom. During an interview on 12/2/2025 at 2:41 PM, Certified Nursing Assistant 1 (CNA 1) stated Resident 2 goes to the bathroom by herself. CNA 1 also stated Resident 2's roommate was moved out because of the water leak but not Resident 2. CNA 2 also stated a tall bucket was placed on 11/15/2025 where the drip or leak from the ceiling was coming from. CNA 1 further stated Resident 2 should have been moved to a different room so that if water splashed on floor or the resident may accidentally trip on the bucket, Resident 2 would not slip and fall when the resident goes to the bathroom. During an interview on 12/2/2025 at 2:49 PM, the Director of Nursing (DON) stated Resident 2 was not moved to a different room when the facility noted the leak in Resident 2's room. The DON also stated there was a possibility that the rainwater might not drip into the bucket and Resident 2 could slip and fall or Resident 2 can trip herself with the tall bucket in the room. The DON also stated the facility should have provided a floor mat and a sign that indicated the floor was wet. During an interview on 12/2/2025 at 4:07 PM, Resident 2 was observed in her room lying in bed and stated she goes to the bathroom by herself. Observed a water mark on the ceiling in Resident 2's room located above Bed A and near the restroom. Resident 2 also stated the ceiling in her room by Bed B was leaking water from the rain (did not remember the exact date) and heard the drips from the ceiling. Resident 2 further stated she did not remember if there was a bucket to catch the water dripping from the ceiling but there was no safety cone saying the floor was wet or hazard signs on the floor where the dripping was. During another interview with the DON on 12/2/2025 at 4:15 PM, the DON stated it is important to do proper maintenance of the building roofing for the safety of the residents in the facility. During a review of the facility's Policy and Procedure (P&amp;P) titled, Maintenance Services, revised 12/2009, the P&amp;P indicated that maintenance service shall be provided to all areas of the building, grounds, and equipment. 2. During an observation on 12/2/2025 at 9:56 AM, the Hoyer Lift weighing scale was left outside Room A with leg part expanded and faced towards the hallway and a shower chair placed directly across/ parallel to the Hoyer lift. During a concurrent observation and interview on 12/2/2025 at 3:20 PM, CNA 2 stated the Hoyer lift should be parked by rehabilitation department after being used and not outside the residents' room where the Hoyer lift was currently at because it may cause resident's or staff to trip and fall. During an interview on 12/2/2025 at 3:31 PM, Licensed Vocational Nurse 1 (LVN 1) stated that the Hoyer lift should have been placed in the area or hallway where no residents and staff walks and not outside the resident's room because it can be an accident/trip hazard. LVN 1 also stated the Hoyer lift should have been placed back in the rehabilitation department where it is safe to leave it. During an interview on 12/2/2025 at 3:51 PM, the DON stated the shower chair and Hoyer lift are accidents hazards if placed along the hallway where residents and staff pass by. The DON also stated the shower chair should have been placed back inside the shower room and the Hoyer lift placed near the rehabilitation</p>		