STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056316	A. Building B. Wing	02/04/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Camellia Gardens Care Center	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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to report an injury of unknown origin (the source of the injury was not witnessed by any person and the source of the injury could not be explained by the resident and the injury is suspicious because of its extent, location, the number of injuries at a time, or the number of injuries over time) to California Department of Public Health (CDPH), local law enforcement, and Ombudsman (an official appointed to investigate individuals' complaints against the facility) within two (2) hours from when the resident was noted to have dark purple discoloration on the right eye for one (1) of 2 sampled residents (Resident 1) in accordance with the facility's policy and procedure (P&P) titled, Abuse Investigation and Reporting. This deficient practice had the potential to place Resident 1 at risk for further abuse (willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish) and resulted in a delay in the investigation. Findings: During a review of Resident 1's admission Record, the admission Record indicated Resident 1 was admitted to the facility on [DATE] with the diagnoses including but not limited to dependence on respirator (ventilator, a life-support machine that mechanically assists or replaces spontaneous breathing by moving breathable air into and out of the lungs) status, nontraumatic intracerebral hemorrhage (a sudden type of stroke caused by bleeding within the brain tissue) in cerebellum (structure located at the back of the brain), and encounter for attention to tracheostomy (a surgical procedure to create an opening through the neck into the windpipe to provide direct airway, bypassing the mouth and nose). During a review of Resident 1's Minimum Data Set (MDS, a resident assessment tool), dated 11/12/2025, the MDS indicated Resident 1's cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decision making were severely impaired. The MDS indicated Resident 1 was dependent (helper does all of the effort, resident does none of the effort to complete the activity) for toileting hygiene, personal hygiene, and rolling left and right. During a review of Resident 1's Change of Condition (COC, tool used by health care professionals when communicating about critical changes in a resident's status), dated 1/27/2026, the COC indicated Resident 1 was noted with discoloration on right eye. The COC also indicated, upon further assessment, Resident 1 was noted with dark purple discoloration on right eye, skin is intact but discolored. During an observation on 2/4/2026 at 12:09 PM in Resident 1's room, Resident 1 was lying in bed with greenish to yellowish discoloration on the right corner of the resident's eye with a small red lined mark in the center of the discoloration. During a concurrent observation and interview on 2/4/2026 at 12:10 PM in Resident 1's room with the Director of Nursing (DON), the DON stated there is a little bit of bruising that looks grayish in color and almost like a linear red scratch on Resident 1's right eye. During an interview on 2/4/2026 at 12:18 PM with Treatment Nurse (TN), TN stated he first saw Resident 1's discoloration on the right eye on 1/27/2026 (8 days ago). TN stated on 1/27/2026 around 3 PM, RN Supervisor (RNS) asked him if he (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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	(TN) had noticed Resident 1's bruise. TN stated he went to look at Resident 1's eye after RNS informed him and saw Resident 1 had a light purple discoloration on Resident 1's right eye. TN stated staff did not know the cause of Resident 1's right eye discoloration. TN stated he did not measure the discoloration of Resident 1's right eye and only reported Resident 1's discoloration on the right eye to the physician and responsible party. During a concurrent interview and record review on 2/4/2026 at 12:31 PM with the DON, Resident 1's COC dated 1/27/2026 was reviewed. The DON stated on 1/27/2026 the COC indicated Resident 1 had right eye discoloration. The DON stated since Resident 1 had a bruise on the resident's right eye, the most important thing to determine is the cause of the bruise to rule out potential for abuse. The DON stated the facility needed to investigate to determine if there were any incidents with a particular staff and to see how staff handled Resident 1. The DON also stated she was unaware of how Resident 1 obtained the discoloration to the resident's right eye. The DON stated since the facility staff did not know how Resident 1 got the dark purple discoloration on the resident's right eye, this was an injury of unknown origin and should have been treated as a potential abuse case. The DON stated, since it is a potential for abuse case it should have been reported within the two- hour time frame from when the injury was observed or noted on 1/27/2026. During an interview on 2/4/2026 at 12:51 PM with Certified Nursing Assistant 1 (CNA 1), CNA 1 stated on 1/28/2026 she went into Resident 1's room to turn on the light and gasped when she saw Resident 1's right eyes with discoloration. CNA 1 stated Resident 1, she has a black eye. CNA 1 stated Resident 1's eye was purple in color noted underneath the resident's right eye and to the right side of the eye. During an interview on 2/4/2026 at 1:21 PM with RNS, RNS stated on 1/27/2026 Resident 1 had redness under the resident's eyes where the eye bags were located. RNS stated she was not sure what happened to cause Resident 1's eyes to become red. RNS stated TN did not inform her of TN's assessment of dark purple discoloration to the eye. RNS stated TN should have informed RNS so that they could report to the Administrator (ADM) right away since they were suspecting abuse and it should have been reported to CDPH, police and ombudsman. During a concurrent interview and record review on 2/4/2026 at 2:01 PM with the ADM, the facility's policy and procedure (P&P) titled Investigating Resident Injuries dated 04/2021 was reviewed. ADM stated according to the P&P, if the nursing and medical assessment determines an injury of unknown source the investigation will follow the protocols set forth in the facility's established abuse reporting and investigation guidelines. During an interview on 2/4/2026 at 2:15 PM with the Licensed Vocational Nurse (LVN), LVN stated on 1/27/2026 she noticed Resident 1 had some discoloration on the right side of the eye. LVN stated she did not know what happened to Resident 1's eye and she did not report it to CDPH, ombudsman or police. During a concurrent interview and record review on 2/4/2026 at 4:08 PM with the DON, the facility's P&Ps titled Abuse Investigation and Reporting dated 12/2018 was reviewed. The P&P indicated all reports of resident abuse and/or injuries of unknown source (abuse') shall be promptly reported to local, state and federal agencies (as defined by current regulations) and thoroughly investigated by facility management. The P&P also indicated the Administrator or designated representative will notify law enforcement immediately by telephone of an initial report of alleged abuse. The DON stated she was not informed of Resident 1's injury of unknown origin and should have been informed of Resident 1's right eye dark purple discoloration noted on 1/27/2026. The DON stated promptly in their P&P means within the two- hour time frame from the suspected abuse and Resident 1's discoloration on the right eye was not reported to CDPH, police, and Ombudsman within two hours. The DON stated the importance of reporting was to start with the investigations of abuse, to find the root cause, and to rule out abuse. During an interview on 2/4/2026 at 4:45 PM with the ADM, the ADM stated staff did not report Resident 1's (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	injury of unknown origin noted on 1/27/2026 and should have informed the ADM of Resident 1's right eye dark purple discoloration.