

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555213	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/01/2025
NAME OF PROVIDER OR SUPPLIER Pasadena Care Center, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 1640 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)
<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46087</p> <p>Based on observation, interview, and record review, the facility failed to ensure one of three sampled residents (Resident 2) were free from physical abuse (the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish), when Resident 1 allegedly scratched Resident 2's face on 3/18/2025.</p> <p>This deficient practice resulted in Resident 1 had a scratch to his nose and had the potential to negatively affect Resident 1's comfort and psychosocial (having to do with the mental, emotional, social, and spiritual effects of a disease) well-being which can lead to hospitalization and/ or death.</p> <p>Findings:</p> <p>During a review of Resident 1's Admission Record, indicated Resident 2 was admitted to the facility on [DATE] with diagnoses that included Alzheimer's disease (a disease characterized by a progressive decline in mental abilities), dementia (a progressive state of decline in mental abilities), and lack of coordination.</p> <p>During a review of Resident 1's Minimum Data Set (MDS, a resident assessment tool), dated 3/18/2025, the MDS indicated Resident 1's cognitive (ability to think and reason) skills for daily decision making was severely impaired (never/rarely made decisions). The MDS indicated Resident 1 required substantial/maximal assistance (helper does more than half the effort) with eating. The MDS indicated Resident 1 is dependent (helper does all the effort) with oral hygiene, toileting hygiene, shower/bath, upper body dressing, lower body dressing, and putting on/taking off footwear. The MDS indicated Resident 1 is dependent with sit to stand and chair/bed to chair transfer.</p> <p>During a review of Resident 1's late entry progress notes dated 3/18/2025, timed 10:30 PM, documented by Licensed Vocational Nurse (LVN) 1, indicated a situation of alleged minor altercation. The progress notes indicated Resident 1 was observed exhibiting verbal aggression, yelling at staff, wandering the hallways and goes room to room. The progress notes indicated Certified Nurse Assistant (CNA) 1 followed Resident 1 closely and indicated Resident 1 abruptly entered Room A and scratched another resident (Resident 2) on the nose. The progress notes also indicated CNA 1 was unable to prevent the incident as it occurred suddenly.</p> <p>(continued on next page)</p>

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 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a review of Resident 2's Admission Record, indicated Resident 2 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included cellulitis (a common bacterial skin infection that affects the deeper layers of the skin and underlying tissues, often characterized by redness, swelling, pain, and warmth) of lower limbs, benign prostatic hyperplasia (common condition in men, particularly as they age, where the prostate gland [small gland located below the bladder], grows larger than normal), and gastro-esophageal reflux disease (when stomach contents, including acid, flow backward from the stomach).</p> <p>During a review of Resident 2's MDS dated [DATE], the MDS indicated Resident 2's cognitive skills was intact for daily decision making with modified independence (some difficulty in new situations only). The MDS indicated Resident 2 required supervision or touching assistance (helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity) with eating. The MDS indicated Resident 2 required substantial/maximal assistance with oral hygiene, upper body dressing, and personal hygiene. The MDS also indicated Resident 2 is dependent with toileting hygiene, shower/bathe, lower body dressing, and putting on/taking off footwear.</p> <p>During a review of Resident 2's SBAR (situation, background, assessment, recommendation-a communication tool used by healthcare workers when there is a change of condition among the residents) dated 3/18/2025, by Registered Nurse (RN) 1, indicated a situation of alleged physical abuse by another resident, and sustained scratch on nose. The SBAR indicated treatment order to nose scratch was obtained from Resident 2's Doctor.</p> <p>During a review of Resident 2's Treatment Administration Record for the month of March 2025, indicated a treatment to scratch in nose area, cleanse with normal saline (a sterile solution of 0.9% of sodium chloride in water used for hydration and wound cleaning/ flushing solution), solution, pat dry and leave open to air, once a day for 7 days, ordered on 3/19/2025.</p> <p>During a concurrent observation and interview on 4/1/2025 at 2:30 PM with Resident 2, in Resident 2's room, Resident 2 was observed lying in bed, and Resident 2 stated a female resident (Resident 1) came to my room a few nights ago, and she (Resident 1) scratched my face, and end up having scratched in my nose. Resident 2 stated there was a staff (CNA 1) standing behind Resident 1's wheelchair, and did not do anything to prevent Resident 1 from getting up from the wheelchair and attacked Resident 2 while he was lying in bed that night.</p> <p>During an interview on 4/1/2025 at 3:50 PM with CNA 1, CNA 1 stated he was working on 3/18/2025, evening shift (3 PM - 11 PM). CNA 1 stated CNA 1 was following Resident 1 who was sitting in wheelchair and wheeling himself (Resident 1) around, from west station where Resident 1's room is, until Resident 1 entered east station and got up from wheelchair and entered Room A and attacked Resident 2 who was in bed. CNA 1 added, CNA 1 he turned his head away from Resident 1 and when he turned back his head to look at Resident 1, Resident 1 was already standing next to Resident 2's bed, and Resident 1 was attacking Resident 2's face in scratching manner.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 4/1/2025 at 4 PM with LVN 2, LVN 2 stated he is familiar with Resident 1, and stated He was not working when the incident of Resident 1 scratching Resident 2's face on 3/18/2025. LVN 2 added Resident 1 required supervision when Resident 1 started getting verbally aggressive because there is probability of Resident 1 becoming physically aggressive to staff and to other residents as well. LVN 2 also added, Resident 1 is new to the facility, and they are still monitoring Resident 1's aggressive behavior and the staff following and supervising Resident 1 could have prevented Resident 1 from entering another resident's room if that staff is really watching Resident 1.</p> <p>During an interview on 4/1/2025 at 4:10 PM with Registered Nurse (RN), RN stated she was made aware on 3/19/2025 that there was a resident-to-resident altercation between Resident 1 and 2 in Resident 2's room (Room A). RN stated she went to Resident 2's room, where the alleged incident happened, and RN observed Resident 2 in bed, with a scratch on Resident 2's nose. RN stated Resident 2 claimed that Resident 1 attacked Resident 2, and that Resident 2 end up obtaining a scratch in his nose. RN stated based on the nurse's notes that was documented, dated 3/18/2025, evening shift by LVN 1, RN stated that Resident 1 seemed to be out of her room that evening and is being followed by CNA 1, and suddenly, Resident 1 got up from the wheelchair and entered Room A, and attacked Resident 2 who was in bed. RN stated, Resident 1's room is in another station (east station), and Resident 2 is in another station (west station), and the incident could have been prevented when licensed nurse and other staff members such as the CNAs working on that shift, redirected Resident 1 accordingly and maneuvered the wheelchair when Resident 1 seemed to be going further from her room or entering another resident's room.</p> <p>During a review of the facility's Policy and Procedure (P&P), titled Abuse and Neglect Prevention Management, revised in April 2024, indicated the facility will ensure our residents safe and free from abuse. The P&P indicated the residents have the right to be free from abuse by anyone, including staff members, other residents, visitors, volunteers, family, friends, or any other individual.</p> <p>During a review of Facility's P&P titled Dementia-Clinical Management, revised in April 2024, indicated the staff will monitor the individual with dementia.</p>		