STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555893	A. Building B. Wing	04/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pasadena Nursing Center	1570 North Fair Oaks Ave Pasadena, CA 91103

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48395 Based on interview and record review the facility failed to prevent and stop an incident of verbal abuse (a range of words or behaviors used to manipulate, intimidate, and maintain power and control over someone) for one of two sampled residents (Resident 1) when Resident 2 called Resident 1 racial (discrimination and prejudice against people based on their race or ethnicity) slurs (an insinuation or allegation about someone that is likely to insult them or damage their reputation) and Resident 2 attempted to hit and spitted at Resident 1. This failure placed Resident 1 at risk for psychosocial harm such as feeling unsafe and anxious. Findings: 1. During a review of Resident 1's Admission Record, Admission Record indicated the resident was initially admitted to the facility on [DATE] with diagnoses of post-traumatic stress disorder (PTSD; a disorder that develops when a person has experiences or witnessed a scary, shocking, terrifying, or dangerous event) and anxiety disorder (a condition which a person has excessive worry and feelings of fear, dread, and uneasiness). During a review of Resident 1's History and Physical Examination (H&P), dated 3/30/2024, H&P indicated the resident is competent to understand her medical condition and patient bill of rights (a document that provides patients with information on how they can reasonably expect to be treated during the course of their medical stay) as presented by the staff. During a review of Resident 1's Minimum Data Set (MDS - a standardized resident assessment care screening tool), dated 4/4/2024, the MDS indicated the resident was cognitively intact (ability to think, remember, and reason), and needed supervision or touching assistance (helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity) for transfers (how resident moves to and from bed, chair, wheelchair, standing position), walking, toileting, dressing (how a resident puts on, fastens and takes off all items of clothing), and personal hygiene and was independent with eating. 2. During a review of Resident 2's Admission Record, Admission Record indicated the resident was initially admitted to the facility on [DATE] diagnoses of metabolic encephalopathy (damage or disease that affects the brain) and cerebral infarction (damage to the tissues in the brain due to a loss of oxygen). (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 2's H&P, dated 1/19/2024, H&P indicated the resident is not competent to understand her medical condition and patient's bill of rights. During a review of Resident 2's MDS, dated [DATE], MDS indicated the resident was severely impaired (difficulty with or unable to make decisions, learn, remember things) with cognitive (ability to think, remember, and reason) decision making, and needed supervision or touching assistance with transfers, walking, dressing and personal hygiene and was independent with eating. During a record review of Resident 1's progress note dated 4/9/2024 at 11:12 PM signed by Licensed Vocational Nurse 1 (LVN 1), Resident 1's progress note indicated Resident 1 came to the nurses station to complain to LVN 1 that Resident 2 was using racist slur language towards her and that LVN 1 observed Resident 2 attempt to hit Resident 1 and spitted at Resident 1. During an interview on 4/17/2024 at 10:05 AM with Resident 1, Resident 1 stated that on 4/9/2024, she got into an argument with her roommate, Resident 2, about leaving their bedroom door open. Resident 1 also stated, after speaking with LVN 1 at the nurses station, Resident 1 stated, as she was walking back inside her room, Resident 2 called her a racial slur in front of LVN 1. Resident 1 then stated that moments later at the nurse's station again, she was expressing to LVN 1 that she did not feel safe due to being called a racial slur by Resident 2, and in that moment Resident 2 came out of the room yelling at her and continuing to call her racial slurs and spit at her in front of LVN 1. During an interview on 4/17/2024 at 10:54 AM with LVN 1, LVN 1 stated on 4/9/2024 around 10:30 PM, Resident 1 came up to the nurse's station stating that Resident 2 had called Resident 1 a racial slur and did not want Resident 2 in her room. LVN 1 then stated Resident 2 overheard them talking and started yelling at Resident 1and spit at her. During an interview on 4/17/2024 at 11:26 AM with Certified Nursing Assistant (CNA), CNA stated that on 4/9/2024, Resident 1 and Resident 2 got into a disagreement and when Resident 1 came up to the nurse's station to ask LVN 1 to change rooms or de-escalate (to decrease in intensity) the situation, Resident 2 came out and called Resident 1 a racial slur. CNA also stated that after Resident 2 was separated from Resident 1, the staff had her sitting in the hallway where Resident 2 continued to yell out the racial slurs toward Resident 1 for about 5 to 10 minutes. During an interview on 4/17/2024 at 12:01 PM with Minimum Data Set Nurse (MDSN), MDSN stated that he would consider a person yelling out racial slurs towards another person as verbal abuse and that someone trying to hit and spit would also be considered abuse. During an interview on 4/17/2024 at 12:15 PM with LVN 2, LVN 2 stated he would consider someone yelling racial slurs at another person verbal abuse. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 4/17/2024 at 12:26 PM with Registered Nurse (RN), Resident 1's progress note dated 4/9/2024 at 11:12 PM signed by LVN 1 was reviewed. Resident 1's progress note indicated an altercation of Resident 2 calling Resident 1 a racial slur and attempting to hit and spitted at her. RN stated that she would consider calling someone a racial slur as verbal abuse and stated in the incident between Resident 1 and Resident 2, they should have been immediately separated and monitored to make sure the residents were okay. RN also stated the incident should have been reported as well as the residents' primary doctors called to see if there were any interventions that needed to be ordered such as a psychiatry (the branch of medicine focused on the diagnosis, treatment and prevention of mental, emotional and behavioral disorders) consultation. During an interview on 4/17/2024 at 1:40 PM with Social Services Director (SSD), SSD stated she considers derogatory (intended to lower the reputation of a person or thing) terms and racial slurs verbal abuse and stated that in that instance, Resident 1 and 2 should have been separated and monitored to make sure the residents were okay. SSD also stated that it is important to assess residents for their possible triggers so that they could feel safe in the facility and if ever Resident 1 expressed feelings of not feeling safe RN would monitor Resident 1 and ask the resident what RN could do to help change that. During a review of the facility's police and procedure (P&P) titled Preventing Resident Abuse revised December 2013, the P&P indicated, Our facility will not condone any form of resident abuse and will continually monitor our facility's policies, procedures, training programs, systems, etc., to assist in preventing resident abuse, with the policy interpretation and implementation stating: The facility's goal is the achieve and maintain an abuse-free environment. Instructing staff about how cultural, religious and ethnic differences can lead to misunderstanding and conflicts; Monitoring staff on all shifts to identify inappropriate behaviors towards residents (for example [e.g.], using derogatory language). During a review of the facility's policy and procedure (P&P) titled Abuse Prevention Program revised December 2016, the P&P indicated, Our residents have the right to be free from abuse. The P&P also indicated the abuse includes verbal abuse and the administration will: Protect our residents from abuse by anyone including, but not necessarily limited to: facility staff, other residents, consultants, volunteers, staff from other agencies, family members, legal representatives, friends, visitors, or any other individual. Identify and assess all possible incidents of abuse.

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(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** 48395 Based on interview and record review the facility failed to report within two hours to the state agency (CDPH; California Department of Public Health), the state ombudsman (advocates for residents of nursing homes, board and care homes and assisted living facilities), and local law enforcement (Local PD) of an allegation of verbal abuse (a range of words or behaviors used to manipulate, intimidate, and maintain power and control over someone) for one of two sampled residents (Resident 1). This failure resulted in the facility not reporting the alleged verbal abuse and putting Resident 1 at further risk of more episodes of verbal abuse by Resident 2. Findings: 1. During a review of Resident 1's Admission Record, Admission Record indicated the resident was initially admitted to the facility on [DATE] with diagnoses of post-traumatic stress disorder (PTSD; a disorder that develops when a person has experiences or witnessed a scary, shocking, terrifying, or dangerous event) and anxiety disorder (a condition which a person has excessive worry and feelings of fear, dread, and uneasiness). During a review of Resident 1's History and Physical Examination (H&P), dated 3/30/2024, H&P indicated the resident is competent to understand her medical condition and patient bill of rights (a document that provides patients with information on how they can reasonably expect to be treated during the course of their medical stay) as presented by the staff. During a review of Resident 1's Minimum Data Set (MDS - a standardized resident assessment care screening tool), dated 4/4/2024, the MDS indicated the resident was cognitively intact (ability to think, remember, and reason), and needed supervision or touching assistance (helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity) for transfers (how resident moves to and from bed, chair, wheelchair, standing position), walking, toileting, dressing (how a resident puts on, fastens and takes off all items of clothing), and personal hygiene and was independent with eating. 2. During a review of Resident 2's Admission Record, Admission Record indicated the resident was initially admitted to the facility on [DATE] with diagnoses of metabolic encephalopathy (damage or disease that affects the brain) and cerebral infarction (damage to the tissues in the brain due to a loss of oxygen). During a review of Resident 2's H&P, dated 1/19/2024, H&P indicated the resident is not competent to understand her medical condition and patient's bill of rights. During a review of Resident 2's MDS, dated [DATE], the MDS indicated the resident was severely impaired (difficulty with or unable to make decisions, learn, remember things) with cognitive decision making, and needed supervision or touching assistance with transfers, walking, dressing and personal hygiene and was independent with eating. (continued on next page)

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(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	During a record review of Resident 1's progress note dated 4/9/2024 at 11:12 PM signed by Licensed Vocational Nurse 1 (LVN 1), Resident 1's progress note indicated Resident 1 came to the nurses station to complain to LVN 1 that Resident 2 was using racist (discrimination and prejudice against people based on their race or ethnicity) slur (an insinuation or allegation about someone that is likely to insult them or damage their reputation) language towards her and that LVN 1 observed Resident 2 attempted to hit Resident 1 and spitted at Resident 1. During an interview on 4/17/2024 at 10:05 AM with Resident 1, Resident 1 stated, on 4/9/2024, she got into an argument with her roommate (Resident 2) about leaving their bedroom door open. Resident 1 also stated, after speaking with LVN 1 at the nurse's station, Resident 1 stated that as she was walking back inside her room, Resident 2 called her a racial slur in front of LVN 1. Resident 1 then stated that moments later at the nurse's station again, she was expressing to LVN 1 that she did not feel safe due to being called a racial slur by Resident 2, and in that moment Resident 2 came out of the room yelling at her and continuing to call her racial slurs and spit at her in front of LVN 1. During an interview on 4/17/2024 at 10:54 AM with LVN 1, LVN 1 stated on 4/9/2024 around 10:30 PM, Resident 1 came up to the nurse's station stating that Resident 2 had called her a racial slur and did not want Resident 2 in her room. LVN 1 then stated that Resident 2 overheard them talking and started yelling at Resident 1 and spitted at Resident 1. LVN 1 further stated after the incident, Resident 2 was moved to another room and that she did not report the incident at all and only charted about it and mentioned it to the next shift. During an interview on 4/17/2024 at 11:26 AM with Certified Nursing Assistant (CNA), CNA stated that on 4/9/2024, Resident 1 and Resident 2 got into a disagreement and when Resident 1 came up to the nurse's station to ask LVN 1 to change rooms, Resident 2 came out and called Resident 1 a racial slur. CNA also stated that after Resident 2 was separated from Resident 1, the staff had her sitting in the hallway where Resident 2 continued to yell out the racial slurs toward Resident 1 for about 5 to 10 minutes. During an interview on 4/17/2024 at 12:01 PM with Minimum Data Set Nurse (MDSN), MDSN stated that he would consider a person yelling out racial slurs towards another person as verbal abuse and that someone trying to hit, and spit would also be considered abuse. MDSN also stated that all allegations of suspected and/ or witnessed abuse need to be reported within two hours from the incident to the appropriate agencies including the police, ombudsman, and CDPH. During an interview on 4/17/2024 at 12:15 PM with LVN 2, LVN 2 stated he would consider someone yelling racial slurs at another person verbal abuse and would report any allegation of abuse immediately to the facility's Administrator who is their abuse coordinator, CDPH, the ombudsman and the police. During a concurrent interview and record review on 4/17/2024 at 12:26 PM with Registered Nurse (RN), Resident 1's progress note dated 4/9/2024 at 11:12 PM signed by LVN 1 was reviewed. Resident 1's progress note indicated an altercation of Resident 2 calling Resident 1 a racial slur and attempting to hit and spit at her. RN stated the incident should have been reported and that she would consider calling someone a racial slur as verbal abuse. RN further stated the timeline for reporting is within 2 hours after being made aware of the abuse allegation and that it's integral that it is reported for the safety of the residents. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 4/17/2024 at 1:40 PM with Social Services Director (SSD), SSD stated she considers derogatory (intended to lower the reputation of a person or thing) terms and racial slurs verbal abuse and stated that any allegation of abuse should be reported within 2 hours. SSD further stated that it's important to report any abuse allegation for the resident's safety. During a concurrent interview and record review on 4/17/2024 at 2:36 PM with MDSN, Resident 1's progress note dated 4/9/2024 at 11:12 PM signed by LVN 1 was reviewed, Resident 1's progress note indicated an altercation of Resident 2 calling Resident 1 a racial slur and attempting to hit and spit at her. MDSN stated that the incident should have been reported by LVN 1. During an interview on 4/17/2024 at 3:15 PM with LVN 1, LVN 1 stated the incident she witnessed between Resident 1 and 2 on 4/9/2024 should have been reported to CDPH, local PF and ombudsman. LVN 1 also stated she should have documented better and called the Administrator to let her know about the situation. During a review of the facility's policy and procedure (P&P) titled Abuse Prevention Program revised December 2016, the P&P indicated, As part of the resident abuse prevention program, the administration will investigate and report any allegation of abuse within timeframes as required by federal requirements. During a review of the facility's policy and procedure (P&P) titled Abuse Investigation and Reporting revised July 2017, the P&P indicated: All alleged violation involving abuse, neglect (a situation in which you do give enough care or attention to someone or something), exploitation (the act of selfishly taking advantage of someone or a group of people in order to profit from them or otherwise benefit oneself), or mistreatment (when behavior shows disrespect for the dignity of others), including injuries of an unknown source and misappropriation of property will be reported by the facility administrator, or his/her designee, to the following persons or agencies: o The State licensing/certification agency responsible for surveying/licensing the facility; o The local/State Ombudsman; o The Resident's Representative (Sponsor) of Record; o Law enforcement officials; An alleged violation of abuse, neglect, exploitation or mistreatment (including injuries of unknown source and misappropriation of resident property) will be reported immediately but no later than: o Two (2) hours if the alleged violation involves abuse OR has resulted in serious bodily injury; or