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	02/25/2025

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** 45456 Based on observation, interview, and record review, the facility failed to prevent physical abuse (willful infliction of injury which includes, but is not limited to, hitting, slapping, punching, biting, and kicking) for one (1) of 2 sampled residents (Resident 1). This failure resulted to Resident 1 striking Resident 2 on the head on 2/7/2025, leaving a lump on the left side of Resident 2 ' s head while Resident 1 suffered right hand swelling. Findings: 1.During a review of Resident 1 ' s Admission Record, the admission record indicated Resident 1 was admitted to the facility on [DATE] and re- admitted on [DATE]. Resident 1 ' s diagnoses included schizoaffective disorder (a chronic mental illness that causes a person to experience dramatic changes in their thoughts, moods, and behaviors), bipolar disorder (a mental illness that causes unusual shifts in a person's mood, energy, activity levels, and concentration), mood affective disorder (a type of mental health condition where there is a disconnect between actual life circumstances and the person's state of mind or feeling), and anxiety disorder (a disorder characterized by nervousness characterized by a state of excessive uneasiness and apprehension, typically with compulsive behavior [repetitive, persistent, and often uncontrollable actions that a person feels driven to perform] or panic attacks). During a review of Resident 1 ' s Minimum Data Set (MDS, a resident assessment tool), dated 12/30/2024, the MDS indicated Resident 1 has intact cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decision making. The MDS indicated Resident 1 was independent (resident completes the activity by themself with no assistance from a helper) in eating, oral hygiene, toileting hygiene, upper and lower body dressing, putting on and taking off footwear, roll left and right, sit to lying, sit to stand, chair/ bed-to-chair transfer, toilet transfer, walk 10, 50, and 150 feet. During a review of Resident 1 ' s Change of Condition (COC) notes, dated 2/7/2025, timed at 11:25 AM, the COC indicated Resident 1 had swelling on the right hand. The COC indicated that Resident 1 had behavior exacerbation, with audio and visual hallucinations (are sensory experiences where a person perceives sounds and sights that are not present in reality) causing him to get angry and strike his roommate (Resident 2) on the forehead on 2/7/2025. (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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 1 ' s Care Plan (CP), initiated on 1/5/2025, the CP indicated altered behavior patterns related to schizophrenia (a serious mental illness that affects how a person thinks, feels, and behaves) manifested by slamming doors, yelling at nurses and stated the walls told him they put shit in the food. The staff interventions included were to: a. Notify any risk/consequences as a result of non-compliance. b. Provide explanation /rationale of care for better compliance of Resident c. de-escalate (methods and actions taken to decrease the severity of a conflict, whether of physical, verbal or another nature) redirect and medicateResident 1 d. Notify doctor of resident ' s physical aggression (behavior intended to cause or threaten physical harm to others, encompassing actions like hitting, kicking, biting, or using weapons) e. Discuss goals with the Resident once he calmed down and encourage him to discuss concerns, letting staff know when he feels he is hearing voices directing him to destroy items. Resident was agreeable to communicating with staff expressing feelings and concerns to prevent episodes. f. Respect Resident ' s rights During a review of Resident 1 ' s CP, initiated on 1/25/2025, the CP indicated Resident 1 had an episode of non -contact physical aggression by punching the TV in his room and tore it off the wall. The staff interventions included were to: a. Notify any risk/consequences as a result of non-compliance. b. Provide explanation /rationale of care for better compliance of Resident c. de-escalate redirect and medicate Resident 1 d. Notify doctor of resident ' s physical aggression. e. Discuss goals with the Resident once he calmed down and encourage him to discuss concerns, letting staff know when he feels he is hearing voices directing him to destroy items. Resident was agreeable to communicating with staff expressing feelings and concerns to prevent episodes. f. Respect Resident ' s rights During a review of Resident 1 ' s CP, initiated on 2/1/2025, the CP indicated Resident 1 continues to have episodes of delusion (an unshakeable belief in something that is untrue, even when there is evidence that it is not real), non-contact aggression towards items, yelling and screaming towards the staff. The staff interventions included were to: a. Notify any risk/consequences as a result of non-compliance. b. Provide explanation /rationale of care for better compliance of Resident (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	c. de-escalate, redirect and medicate Resident 1 d. Notify doctor of resident ' s physical aggression. e. Discuss goals with the Resident once he calmed down and encourage him to discuss concerns, letting staff know when he feels he is hearing voices directing him to destroy items. Resident was agreeable to communicating with staff expressing feelings and concerns to prevent episodes. f. Respect Resident ' s rights 2. During a review of Resident 2 ' s Admission Record, the admission record indicated Resident 2 was admitted to the facility on [DATE] and re- admitted on [DATE]. Resident 2 ' s diagnoses included dementia (a mental disorder in which a person loses the ability to think, remember, learn, make decisions, and solve problems), anxiety disorder depression (a mood disorder that causes a persistent feeling of sadness and loss of interest.) and bipolar disorder. During a review of Resident 2 ' s MDS, dated [DATE], the MDS indicated Resident 2 has severely impaired cognitive skills for daily decision making. The MDS indicated Resident 2 needed supervision or touching assistance (helper provides verbal cues and/or touching/ steadying and/or contact guard assistance as resident completes activity) in eating, oral hygiene, upper and lower body dressing, roll left and right, sit to lying, sit to stand, chair/ bed-to-chair transfer, and toilet transfer. Resident 2 needed partial/ moderate assistance (helper does less than half the effort, helper lifts, hold, or supports trunk or limbs but provides less than half the effort) in toileting hygiene, shower and bathe self, putting on and taking off footwear, walk 10, and 50 feet. During a review of Resident 2 ' s Change of Condition (COC) notes, dated 2/7/2025, timed at 11:58 AM, the COC indicated Resident 2 was a victim of a physical altercation (a dispute between individuals in which one or more persons sustain bodily injury arising out of the dispute) with another Resident (Resident 1) who had a small lump on the resident ' s left temple (the flat area on either side of the head, behind the eye, and between the forehead and ear) The COC indicated that Resident 2 was a victim of physical assault (when someone uses violence to injure or threaten another person. It can include using weapons, pushing, kicking, punching, or throwing things) by another resident (Resident 1). During an interview with Resident 1 on 2/25/2025 at 8:46AM, Resident 1 stated Resident 2 would not stop flipping the lights on and off even when asked to stop. Resident 1 stated, When I went to talk to him (Resident 2), both his fists were up and positioned on a fighting mode. I felt antagonized (to cause someone to feel hostile or angry) so I hit the top of his (Resident 2) head. I do not remember how many times I hit him, but he (Resident 2) did not hit me back. I did it as long as I can. During an observation in Resident 2 ' s room on 2/25/2025 at 8:53AM, Resident 2 was observed on an empty bed next to his, in a side lying position. Resident 2 was mumbling words when answering questions and smiling. Resident 2 ' s pillow and bed sheet were on the floor. During an interview with MDS Nurse (MDSN) on 2/25/2025 at 8:59 AM, MDSN stated, I just heard Resident (Resident 1) cursing and going off, so I came out of my office to see what was going on. I went inside the residents ' (Resident 1 and 2) room, I saw the resident (Resident 1) hitting the other resident (Resident 2) in the head multiple times. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with the Administrator (ADM) on 2/25/2025 at 9:13 AM, ADM stated Resident 2 was a very difficult resident and needed one to one monitoring. ADM also stated Resident 2 has dementia, was aggressive, and wants to hit everybody. ADM also stated Resident 1 broke his TV before. During an interview with the Director of Nursing (DON) on 2/25/2025 at 9:15 AM, the DON stated, Resident (Resident 2) was very aggressive, his behavior was unpredictable. He will just try to punch anyone. Duringan interview with Certified Nursing Assistant 1 (CNA1) on 2/25/2025 at 9:17AM, CNA 1 stated, Resident (Resident 2) was aggressive. He removes his clothes and throws everything like pillow, linen, and water pitcher on the floor. Resident (Resident 2) pulled the call light cord and broke it. He tried to punch somebody, but a staff somebody saw it and stopped it. He cannot stay with another resident. He was aggressive and confused all the time. He always does play the gun motion towards the staff. He was not behaving normal. Now, he is calmer because he is alone in his room after re-admission on 2/13/2025, but when you open the door, he will slam the door in front of you. During an interview with the ADON on 2/25/2025 at 11:40 AM, ADON stated Resident 2 has episodes of spitting, hitting the staff, being agitated, and resistant to participate with Activities of Daily Living (ADLs, are activities related to personal care including bathing or showering, dressing, getting in and out of bed or a chair, walking, using the toilet, and eating), displays gesture of pretending to shoot people using his fingers, and wandering around the hallways. The ADON stated the facility should have addressed these behaviors by implementing interventions to prevent Resident 2 from being a trigger for aggression of other residents. During an interview with MDSN on 2/25/2025 at 11:58AM, MDSN stated, Resident ' s (Resident 2) behaviors should be on the Medication Administration Record (MAR) to ensure that they were monitored. We should have formulated a care plan for the aggressive behaviors, monitored his behavior, and informed the physician. We could have adjusted his medications and revised the care plan. During a concurrent record review of the CNA Documentation Survey Report and interview with ADON on 2/25/2025 at 12:33PM, Report indicated on 2/5/2025 and 2/7/2025, Resident 2 had two episodes of pushing and two episodes of yelling and screaming. ADON stated there was no documentation in the licensed nurses ' notes regarding Resident 2 ' s behaviors and that they were addressed. ADON stated interventions should have included administration of PRN medications, redirection and providing diversion such as taking the resident to the patio/activity room, provide some snacks and provide calm relaxing environment. During an interview with Licensed Vocational Nurse 1 (LVN 1) on 2/25/2025 at 3:54 PM, LVN 1 stated Resident 1 hit Resident 2 on the head because Resident 2 was turning off the lights and turning it back on. LVN 1 stated Resident 2 had a left forehead bump. LVN 1 stated Resident 2 was constantly getting up and down his bed, walks around and with episodes of yelling. During an interview with LVN 1 on 2/25/2025 at 3:59 PM, LVN 1 stated, Prior the physical altercation incident, Resident (Resident 2) had an episode of kicking a CNA (unidentified). (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility ' s Policy and Procedure (P&P) titled, Abuse Prevention and Management, revised 12/2016, the P&P indicated our residents have the right to be free from abuse, neglect, misappropriation of resident property (the illegal use of another person's property for personal gain) and exploitation (the act of using someone or something unfairly for your own advantage). This includes but is not limited to freedom from corporal punishment (a punishment which is intended to cause physical pain to a person), involuntary seclusion (involuntary confinement of a person alone in a room or an area where the person is physically prevented from leaving), verbal (the use of oral, written, or gestured communication, or sounds, to residents within hearing distance, regardless of age, ability to comprehend, or disability), mental (the use of verbal or nonverbal conduct which causes or has the potential to cause the resident to experience humiliation, intimidation, fear, shame, agitation, or degradation), sexual (non-consensual sexual contact of any type with another person) ,or physical abuse, and physical restraint (any mechanical or personal restriction that immobilizes or reduces the free movement of a person's arms, legs or head) or chemical restraint (any drug that is used for discipline or convenience and not required to treat medical symptoms) not required to treat the resident ' symptoms. As part of the resident abuse prevention, the administration will: protect our residents from abuse by anyone including, but not limited to facility staff, other residents, consultants, volunteers, staff from other agencies, family members, legal representatives, friends, visitors, or any other individual. Implement measures to address factors that may lead to abusive situations. During a review of facility ' s P&P titled, Abuse and Neglect- Clinical Protocol, revised on 3/2018, P&P indicated the nurse will assess the individual and document related findings. Assessment data will include c. current behavior; h. behavior over last 24 hours (aggressive behavior). Treatment/ Management: The facility management and staff will institute measures to address the needs of residents and minimize the possibility of abuse and neglect. The physician and staff will address appropriate causes of problematic resident behavior where possible.