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	11/26/2025

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. (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 - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to report an alleged abuse (willful infliction of injury resulting to physical harm/ pain or mental anguish) to the State Survey Agency (California Department of Public Health-CDPH - where state law provides for jurisdiction in long-term care facilities), ombudsman (OMB) (advocates for residents of nursing homes, board and care homes and assisted living facilities), and local law enforcement when OMB and local law enforcement (PD) in accordance with State law within two (2) hours after the allegation was made for two of two sampled residents (Resident 1 and Resident 4). This deficient practice had the potential to place Resident 1 and Resident 4 at risk for further abuse and/or under reporting from the facility. Findings: 1. During a review of Resident 1's admission Record, the admission Record indicated Resident 1 was initially admitted to the facility on [DATE] and was readmitted on [DATE] with diagnoses that included hereditary and idiopathic neuropathy (a disorder causing slow weakness, numbness, tingling, and foot deformities with nerve damage), chronic obstructive pulmonary disease (COPD- a long-term lung disease causing difficulty breathing), bronchiectasis unspecified (a chronic lung condition where the airways become permanently widened and damaged). During a review of Resident 1's Minimum Data Set (MDS- a resident assessment tool), dated 10/16/2025, the MDS indicated Resident 1 was assessed having intact memory and 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 themselves with no assistance from a helper) with eating, toileting/personal hygiene, and upper/lower body dressing. The MDS indicated Resident 1 required setup or clean-up assistance with sit to lying, sit to stand, and toilet transfer. During a review of Resident 1's Change of Condition (COC) form, dated 11/25/2025, the COC indicated Resident 1 came up to staff in the hallway, reporting that a resident in Room A (Resident 4) had allegedly rolled Resident 4's wheelchair into Resident 1's arm. Apparently, the resident (Resident 4) was coming out from the activities room when Resident 1 claims that Resident 4 bumped Resident 1's arm with Resident 4's wheelchair. 2. During a review of Resident 4's admission Record, the admission Record indicated Resident 4 was admitted to the facility on [DATE] with diagnoses that included other COPD, hypertensive heart disease (a medical condition where the heart is affected by high blood pressure), and schizophrenia. During a review of Resident 4's MDS, dated [DATE], the MDS indicated Resident 4 was assessed to have intact memory and cognitive skills for daily decision making. The MDS indicated Resident 4 required supervision or touching assistance with eating, oral/toileting hygiene, upper body dressing, personal hygiene, sit to stand and toilet transfer. The MDS indicated Resident 4 required partial/moderate assistance with shower/bathe self, lower body dressing, and tub/shower transfer. During an interview on 11/26/2025, at 10:37 AM with Resident 1, Resident 1 stated, on 11/25/2025 at approximately 4:40 PM, Resident 4 came out of the Activities Room and saw Resident 1 wheel herself to the Nurse's Station. Resident 1 stated Resident 4 sped up his wheelchair when Resident 4 saw Resident 1 and Resident 4 rammed his wheelchair against Resident 1. Resident 1 stated Resident 4's wheelchair hit her left arm and Resident 4 also kicked her left leg. Resident 1 stated she informed Licensed Vocational Nurse 2 (LVN 2), LVN 3, and the Assistant Director of Nursing (ADON) about the incident with Resident 4. Resident 1 stated she saw the Social Services Director (SSD), ADON, and the Administrator (ADM) go to the office to talk about the incident after it happened. Resident 1 stated the police did not come and talk to her after the incident. During an interview on 11/25/2025, at 12:07 PM, with LVN 2, LVN 2 stated on 11/25/2025, at around 4:45 PM, Resident 1 informed LVN 2 that Resident 4 crashed into her wheelchair and hit her left arm on her way to the Nurse's Station. LVN 2 stated the ADON, Director of Nursing (DON), and Administrator (ADM) were notified about the incident between Resident 1 and Resident 4. LVN 2 stated what Resident 1 reported about the incident with Resident 4 prompted an investigation of an allegation of abuse. LVN 2 stated if an investigation is prompted then abuse was suspected. LVN 2 stated suspected abuse should be reported to CDPH immediately or within two hours of the incident or when the allegation was made. LVN 2 stated he was not sure if the incident between Resident 1 and Resident 4 was reported to CDPH. During an interview on 11/26/2025, at 12:59 PM, with SSD, SSD stated on 11/25/2025, at approximately 5:20 PM, SSD was notified that Resident 4 allegedly ran over and hit by Resident 1's wheelchair. SSD stated he did not know if the incident between Resident 1 and Resident 4 was reported to CDPH. During an interview on 11/26/2025 at 1:13 PM, with the ADM, the ADM stated she was informed

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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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. (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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to administer medication in accordance with the physician's order and to ensure that the administration of controlled medications (a drug or chemical whose manufacture, possession, and use are regulated by the government due to its potential for abuse or addiction) were accurately documented in the Medication Administration Record (MAR) for two (2) of two sampled residents (Resident 2 and 5). This deficient practice had the potential for harm to Resident 2 and 5 due to missed medications and due to an inaccurate record of controlled medication use, and the possible loss of accountability, which could affect the controls against drug loss, diversion, or theft. Findings: 1. During a review of Resident 2's admission Record, the admission Record indicated Resident 2 was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included other seizures (abnormal electrical activity in the brain that happens quickly), unspecified dementia (a brain disorder that results in memory loss, poor judgment and confusion), chronic obstructive pulmonary disease (COPD- a long-term disease causing difficulty breathing), and bipolar disorder (a mental illness that causes unusual shifts in a person's mood, energy, activity levels, and concentration). During a review of Resident 2's Minimum Date Set (MDS- a resident assessment tool), dated 11/18/2025, the MDS indicated Resident 2 was assessed having moderately impaired (decisions poor; cues/supervision required) cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decision making. The MDS indicated Resident 2 required partial/moderate assistance (helper does less than half the effort) with lower body dressing, rolling left and right, and sit to lying. The MDS also indicated Resident 2 required substantial/maximal assistance (helper does more than half the effort) with toileting hygiene, shower/bathe self, sit to stand, and chair/bed-to-chair transfer. During a review of Resident 2's Order Summary Report, dated 11/26/2025, the Order Summary Report indicated a physician order for Clonazepam (a medication used to treat certain seizure and panic disorders [sudden episode of intense fear that triggers severe physical reactions when there is no real danger or apparent cause] oral tablet 1 milligram (mg- unit of measurement) give 1 tablet by mouth three times a day related to other seizures, ordered on 9/16/2025. During a review of Resident 2's MAR, dated 11/1/2025 to 11/30/2025, the MAR indicated Resident 2 was administered Clonazepam 1 mg by mouth on 11/13/2025 and 11/19/2025 at 8 PM by Licensed Vocational Nurse 3 (LVN 3). During a concurrent observation of Resident 2's Clonazepam bubble pack (a card that packages doses of medication within small, clear, or light-resistant amber-colored plastic bubbles), interview, and record review on 11/26/2025, at 3:15 PM, with LVN 1, Resident 2's Narcotic and Hypnotic Record (a controlled substance count sheet of log used to track the entire lifecycle of a controlled medication including the receipt, administration, inventory, and disposal) from 11/12/2025 to 11/26/2025, was reviewed. LVN 1 counted Resident 2's Clonazepam bubble pack and there were two tablets left. LVN 1 stated Resident 2's Narcotic and Hypnotic Record indicated there was no documentation that Clonazepam 1 mg was taken out from the bubble pack and was given to Resident 2 on 11/13/2025 and 11/19/2025 at 8 PM by LVN 3. During the same interview with LVN 1 on 11/26/2025 at 3:15 PM, LVN 1 stated Resident 2's Narcotic and Hypnotic Record indicated there were two Clonazepam tablets left in Resident 2's bubble pack. LVN 1 stated the Narcotic and Hypnotic record matched the actual clonazepam count and if LVN 3 gave the Lorazepam as indicated in Resident 2's MAR last 11/13/2025 and 11/19/2025 then there should be none left in the bubble pack. LVN 1 stated, it means the MAR was signed by LVN 3, but the medication was not given to Resident 2. 2. During a review of Resident 5's admission Record, the admission Record indicated Resident 5 was initially admitted to the facility on [DATE] and was readmitted on [DATE] with diagnoses that included depression (a serious mood illness affecting how you feel, think, and act, characterized by persistent sadness, loss of interest, fatigue, changes in sleep/appetite, and difficulty concentrating), anxiety disorder (excessive, persistent worry and feat that significantly impair daily life), and schizophrenia (a mental disorder that affects the way a person thinks, acts, expresses emotions, perceives reality, and relates to others). During a review of Resident 5's MDS, dated [DATE], the MDS indicated Resident 5 was assessed having moderately impaired cognitive skills for daily decision making. The MDS indicated Resident 5 required supervision or touching assistance with eating, oral/personal hygiene, toileting hygiene, upper body dressing, rolling left and right, sit to lying, sit to stand, and toilet transfer. The MDS indicated Resident 5 also required partial/moderate assistance with shower/bathe self, lower body dressing, tub/shower/transfer, and waling 50 feet (ft- unit of measurement)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to maintain complete and accurate medical records in accordance with accepted professional standards and practices for three (3) of 3 sampled residents (Residents 2, 3, and 4) when Licensed Vocational 1 (LVN 1) and LVN 2 did not document medications administered from 3 PM to 11 PM on 11/25/2025 in the residents' Medication Administration Record (MAR). This deficient practice had the potential to result in a lack of or a delay in delivery of necessary care or services and in medication errors. Findings: 1. During a review of Resident 2's admission Record, the admission Record indicated Resident 2 was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included other seizures (abnormal electrical activity in the brain that happens quickly), unspecified dementia (a brain disorder that results in memory loss, poor judgment and confusion), chronic obstructive pulmonary disease (COPD- a long-term disease causing difficulty breathing), and bipolar disorder (a mental illness that causes unusual shifts in a person's mood, energy, activity levels, and concentration). During a review of Resident 2's Minimum Date Set (MDS- a resident assessment tool), dated 11/18/2025, the MDS indicated Resident 2 was assessed having moderately impaired (decisions poor; cues/supervision required) cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decision making. The MDS indicated Resident 2 required partial/moderate assistance (helper does less than half the effort) with lower body dressing, rolling left and right, and sitting to lying. The MDS also indicated Resident 2 required substantial/maximal assistance (helper does more than half the effort) with toileting hygiene, shower/bathe self, sit to stand, and chair/bed-to-chair transfer. During a review of Resident 2's Order Summary Report, dated 11/26/2025, the Order Summary Report indicated a physician order for the following: a. Buspirone (a medication used to treat anxiety [a natural feeling of worry, fear, or unease] disorder and its symptoms) HCl oral tablet 10 milligrams (mg- unit of measurement) give one (1) tablet by mouth three times a day related to anxiety disorder manifested by (m/b) restlessness causing irritability and frustration, with a start date of 9/17/2025.b. Clonazepam (a medication used to treat seizure disorders and panic [an intense, sudden feeling of fear or terror] disorder) oral tablet 1 mg. To give 1 tablet by mouth three times a day related to other seizures, with a start date of 9/16/2025. c. Donepezil HCl (a medication used to manage symptoms of dementia) oral tablet 10 mg. Give 1 tablet by mouth at bedtime related to unspecified dementia, unspecified severity with other behavioral disturbance, with a start date of 9/16/2025.d. Lithium Carbonate (a medication used to treat bipolar disorder) oral tablet 300 mg give 1 tablet by mouth three times a day, with a start date of 9/16/2025.e. Melatonin (a medication used to regulate sleep) oral tablet 5 mg give 1 tablet by mouth at bedtime for balance circadian rhythm (the pattern the body follows based on a 24 hour day), with a start date of 9/16/2025.f. Memantine HCl (a medication used to treat moderate to severe Alzheimer's disease [a brain disorder that slowly destroys memory and thinking skills and eventually the ability to carry out he simplest tasks]) oral tablet 10 mg give 1 tablet by mouth two times a day related to unspecified dementia, unspecified severity with other behavioral disturbance, with a start date of 9/17/2025.g. Olanzapine (a medication used to treat schizophrenia [a mental disorder that affects the way a person thinks, acts, expresses emotions, perceives reality, and related to others] and bipolar disorder) oral tablet 10 mg give 1 tablet by mouth two times a day related to schizoaffective disorder (a mental illness blending symptoms of schizophrenia with symptoms of bipolar mania [a state or abnormally elevated energy, mood, and activity] or depressive episodes), bipolar type m/b rapid mood swings, calm to agitated and pretending to shoot staff, with a start date of 11/1/2025.h. Trazodone HCl (a medication used to treat major depressive disorder [a mood disorder causing persistent sadness and loss of interest with impacts daily life]) oral tablet 100 mg give 1 tablet by mouth at bedtime related to depression unspecified m/b no motivation or interest in activities of daily living, with a start date of 9/16/2025.i. Antidepressant Trazodone side effects monitoring: indicate letter if observed: A=Sedation; B= Drowsiness; C= Dry mouth; D= Blurred vision; E= Urinary retention; F= Tachycardia; G= Muscle Tremor; H=Agitation; I= Headache; J= Skin rash; K= Photosensitivity; L= Weight gain; NA= None every shift, with a start date of 9/16/2025.j. Antidepressant use Trazodone behavior monitoring- document number of episodes observed of target behavior depression m/b no motivation or interest in activities of daily living every shift for Trazodone use, with a start date of 11/1/2025.k. Antipsychotic (medications that treat mental health conditions) Haloperidol use behavior monitoring: document number of episode per shift of target behavior m/b inability to cope with delusional