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	02/05/2026

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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review, the facility failed to fully inform the resident's conservator (a person or organization appointed by a court to manage the personal car, finances, or both, of an adult who can no longer make their own decisions due to physical or mental limitations) in advance, of the risks and benefits of proposed care for one (1) of two (2) sampled residents (Resident 1) in accordance with the facility policy when an informed consent was not obtained prior to residents use of the following three (3) psychotropic medications (mind - altering or mood-regulating medications). 1. Paliperidone (drug used to treat schizoaffective disorder [a mental illness that can affect thoughts, mood, and behavior] and schizophrenia [a mental illness that is characterized by disturbances in thought]).2. Haldol (drug used to treat schizophrenia).3. Buspirone (anti-anxiety [a feeling of fear, dread, and uneasiness that may occur as a reaction to stress] medication). This deficient practice had the potential for Residents 1 not able to exercise his right to choose his treatment plan.Findings: 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 anxiety disorder (a mental health disorder characterized by feeling of worry, or fear that are strong enough to interfere with one's daily activities), depression (a mood disorder that causes a persistent feeling of sadness and loss of interest), and schizoaffective disorder. During a review of Resident 1's Physician Order Summary Report, dated 1/23/2026, the Physician Order Summary Report indicated the following orders:1. Paliperidone Extended Release (ER) oral tablet 6 milligrams (mg-metric unit of measurement, used for medication dosage and/or amount). Give one tablet by mouth 2 times a day related to schizoaffective disorder, bipolar (sometimes called manic-depressive disorder; mood swings that range from the lows of depression to elevated periods of emotional highs) type manifested by dilutional ideation (stubbornly believing something that is clearly not true, even when proven wrong, and refusing to accept logic or reality) causing him sudden anger, verbal, and physical aggression2. Haldol 5 mg to intramuscularly (IM) every eight (8) hours as needed for schizoaffective disorder, bipolar type for 14 days manifested by poor coping, easily irritated, angered and combative with staff.3. Buspirone Hydrochloride (HCL)oral tablet 30 mg. Give 1 tablet by mouth 2 times a day related to anxiety disorder manifested by poor coping, causing restlessness, irritability and inability to relax. During a review of Resident 1's Minimum Data Set (MDS- a resident assessment tool), dated 1/25/2026, the MDS indicated Resident 1 had an intact cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decision making. The MDS also indicated Resident 1 required supervision (helper provides cues) with toileting, shower, lower body dressing, and putting on/taking off footwear. The MDS further indicated Resident 1 required setup assistance (helper sets up; resident completes activity) with oral hygiene and upper body dressing and was independent with eating. During a review of the Medication Administration Record (MAR) for the month of January 2026, the MAR (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	indicated the following:1. Paliperidone Extended Release (ER) oral tablet 6 mg was given on 1/24/2026 and 1/25/2026 at 9 AM and 5 PM.2. Haldol 5 mg IM was given on 1/24/2026 at 4:47 PM.3. Buspirone HCL oral tablet 30 mg was given on 1/24/2026 and 1/25/2026 at 9 AM and 5 PM. During an interview on 2/5/2026 at 4 PM, Licensed Vocational Nurse 1 (LVN 1) stated Resident 1's 3 psychotropic medications (Paliperidone, Haldol and Buspirone) should have a complete informed consent before administering the medication. LVN 1 also stated Resident 1's conservator should have been informed of the risk and benefits of the 3 psychotropic medications and should have been asked for the conservator's consent to give Resident 1 the psychotropic medications. During a concurrent review of Resident 1's medical record and interview with the Director of Nursing (DON) on 2/5/2026 at 4:15 PM, the DON stated Resident 1 did not have a signed informed consent and should have an informed consent signed by the conservator for the use of psychotropic medications to let the resident or conservator know the reason for the treatment, the nature and the seriousness of the illness that required the medications and be given the choice to either approve giving the psychotropic medication or not. During a review of the facility's Policy and Procedure (P&P) titled, Informed Consent, revised January 16, 2025, the P&P indicated that when initiating a new order or increase in psychotropic drugs, the attending Physician must obtain informed consent from the resident or responsible party.

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review, the facility failed to maintain accurate documentation of Hospice (compassionate care for people who are near the end of life) Care Service notification of the refusal of the psychotropic medications (mind - altering or mood-regulating medications) for one (1) of two (2) sampled residents (Residents 2). This deficient practice resulted in the medical records inaccurate representation of care provided to Resident 2 and had the potential to result in miscommunication between health care providers to ensure the resident's behavioral problems were accurately addressed.Findings:During a review of Resident 2'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 paranoid schizophrenia (a mental illness that is characterized by disturbances in thought) and anxiety disorder (a mental health disorder characterized by feeling of worry, or fear that are strong enough to interfere with one's daily activities). During a review of Resident 2's Minimum Data Set (MDS- a resident assessment tool), dated 1/26/2026, the MDS indicated Resident 2 had severe cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decision making. The MDS also indicated Resident 2 was dependent (helper does all the effort) with shower and required partial/moderate assistance (helper does less than half the effort) with toileting, lower body dressing, and putting on/taking off footwear. The MDS further indicated Resident 2 required supervision (helper provides cues) with oral hygiene and upper body dressing and required setup assistance (helper sets up; resident completes activity) with eating. During an interview on 2/5/2026 at 2:55 PM, Licensed Vocational Nurse (LVN) 2 stated she notified Hospice of Resident 2's refusal of the medications but did not remember if she documented them. LVN 2 also stated Hospice notification should have been documented in Resident 2's progress notes to ensure it was communicated to the rest of the licensed staff who would be providing care to the resident. During an interview on 2/5/2026 at 4 PM, LVN 1 stated the licensed staff would notify the physician or Hospice Care Services (if under Hospice) when the resident refuses the resident's psychotropic or any other medication. LVN 1 also stated physicians or Hospice notifications should be documented in the residents' progress notes to ensure other staff were aware that the resident has been refusing the resident's medications and that it was being communicated to the physician and/ or Hospice care services staff. During an interview on 2/5/2026 at 4:15 PM, the Director of Nursing (DON) stated Hospice notification should be documented in the progress notes to ensure it was communicated to the rest of the staff for continuity of care and ensure appropriate intervention is provided to the resident. During a review of the facility's policy titled, Charting and Documentation, revised July 2017, indicated, all services provided to the resident, progress toward the care plan goals, or any changes in the resident's medical, physical, functional or psychosocial condition, shall be documented in the resident's medical record. The policy also indicated, the medical record should facilitate communication between the interdisciplinary team (a collaborative group of professionals from different disciplines-such as physicians, nurses, therapists, and social workers-who work together, sharing expertise to develop a unified, patient-centered care plan) regarding the resident's condition and response to care. The policy indicated that documentation in the medical record will be objective (not opinionated or speculative), complete, and accurate.