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	05/12/2026

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 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** Based on interview and record review, the facility failed to prevent physical abuse (intentional bodily injury) for one (1) of four (4) sampled residents (Resident 1) when Resident 2 hit Resident 1 on the face on 4/27/2026. This failure had the potential to result in mental and emotional distress for Resident 1.1. During a review of Resident 1's admission Record, the admission Record indicated the resident was initially admitted to the facility on [DATE] and readmitted [DATE] with diagnoses of paranoid schizophrenia (a chronic mental condition where a person loses touch with reality through intense, irrational distrust) and anxiety disorder (a mental health condition characterized by persistent, excessive, and uncontrollable fear or worry that interferes with daily life). During a review of Resident 1'S Minimum Data Set (MDS - a resident assessment tool), dated 4/21/2026, the MDS indicated the resident was cognitively intact (ability to think, remember, and reason) with cognitive skills for daily decision making. The MDS also indicated Resident 1 needed supervision or touching assistance (helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity) with walking 50 feet with two turns, chair/bed-to-chair transfers, going from sitting to standing, upper and lower body dressing (the ability to dress and undress above and below the waist), putting on/taking off footwear and needed setup or clean-up assistance (helper set up or cleans up; resident completes activity) with eating. During a review of Resident 1's Behavior Related Incidents documentation dated 4/27/2026, Resident 1's Behavior Related Incidents documentation indicated Resident 1 was noted to have been involved in a behavior of physical aggression from his roommate, Resident 2. The form indicated under the Interdisciplinary Team (IDT; a group of different professionals who work closely together to solve a complex problem or achieve a shared goal) Recommendations portion, the documentation indicated Resident 1 stated on the day of the altercation, he (Resident 1) went to his room and walked, stopped and looked at his roommate, Resident 2 and made him (Resident 1) feel uncomfortable and stated Resident 2 believed that he (Resident 1) is creepy. Resident 1 stated Resident 2 then swayed his hand and touched the right side of his (Resident 1) face. It also indicated that, upon asking Resident 2 what happened, he (Resident 2) stated he did not like Resident 1.2. During a review of Resident 2's admission Record, the admission Record indicated the resident was initially admitted to the facility on [DATE] and readmitted [DATE] with diagnoses of paranoid schizophrenia and violent behavior. During a review of Resident 2'S MDS, dated [DATE], the MDS indicated the resident was cognitively intact with cognitive skills for daily decision making. It indicated Resident 2 needed partial/moderate assistance (helper does less than half the effort) with walking 50 feet with two turns, chair/bed-to-chair transfers, and going from sitting to standing. The MDS also indicated Resident 2 needed supervision or touching assistance with lower body dressing and putting on/taking off footwear and needed setup or clean-up assistance with upper body dressing, personal hygiene and eating.During a review of Resident 2's Care Plan dated 3/29/2026, Resident 2's Care Plan indicated Resident 2 had a history of a physical altercation with another resident while in a prior board and care facility because Resident 2 did not like the other resident. The Care Plan also indicated an intervention to assist the resident to develop a more (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	appropriate method of coping and interacting and to encourage the resident to express feelings appropriately. During an interview on 5/11/2026 at 10:50 AM with Resident 2, Resident 2 stated on 4/27/2026, he was watching a movie with his roommate, Resident 1 in their room and noticed Resident 1 looking at him funny and did not like how Resident 1 looked at him (Resident 2) and he (Resident 2) punched Resident 1 on the face. During an interview on 5/11/2026 at 11:00 AM with Resident 1, Resident 1 stated on 4/27/2026, Resident 2, who was his roommate at the time had hit him because he (Resident 1) was staring at him (Resident 2). During an interview on 5/11/2026 at 11:30 AM with the Director of Nursing (DON), the DON stated on 4/27/2026, there was an altercation between Resident 1 and 2 when Resident 2 hit Resident 1 in the face. The DON stated Resident 1 told staff that he (Resident 1) knows he was walking and stopped and stared at Resident 2 and thinks that is why Resident 2 hit him (Resident 1). During a concurrent interview and record review on 5/12/2026 at 10:55 AM with the DON, Resident 1's Electronic Medical Record (EMR; a digital collection of medical information about a person such as health history, diagnoses, medicines, tests, allergies, immunizations and treatment plans that is stored on a computer) dated 4/27/2026 to 5/12/2026 was reviewed. Resident 1's EMR did not have a care plan specifically for Resident 1's behavior of stopping and staring at others. The DON stated, there was no care plan initiated for Resident 1's behavior of stopping and staring at others and because it was triggering for Resident 2, it should have been care planned, especially since Resident 1 now has another roommate, it is important to address it so if he does that behavior to someone else, they can try to prevent another altercation in case it is triggering for another resident. During a concurrent interview and record review on 5/12/2026 at 1:55 PM with the DON, the facility's policy and procedure (P&P) titled, Care Plans, Comprehensive Person-Centered, revised 1/29/2026 was reviewed. The P&P indicated, a comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial, and functional needs is developed and implemented to each resident. The P&P also indicated, the interdisciplinary team (IDT), in conjunction with the resident and his/her family or legal representative, develops and implements a compressive, person-centered care plan for each resident and assessments of residents are ongoing and care plans are revised as information about the residents and the residents' condition change. The DON agreed with the policy and stated the purpose of a care plan is to plan the care for the resident and indicates interventions for the nurses to follow so they can monitor that specific behavior. During the same concurrent interview and record review on 5/12/2026 at 1:55 PM with the DON, the facility's P&P titled, Behavioral Assessments, Intervention and Monitoring, revised March 2019 was also reviewed. The P&P indicated the interdisciplinary team will evaluate behavioral symptoms in residents to determine the degree of severity, distress and potential safety risk to the resident, and develop a plan of care accordingly and safety strategies will be implemented immediately to protect he resident and others from harm. The P&P also indicated:Interventions will be individualized and part of an overall care environment that supports physical, functional and psychosocial needs, and strives to understand, prevent or relieve the resident's distress or loss of abilities.Interventions and approaches will be based on detailed assessment of physical, psychological and behavioral symptoms and their underlying causes, as well as the potential situational and environmental reasons for the behavior. The care plan will include, as a minimum:A description of the behavioral symptoms including: frequency, intensity, duration, outcomes, location, environment and precipitating factors or situations;Targeted and individualized interventions for the behavioral and/or psychosocial symptoms;Rationale for the interventions and approaches;Specific and measurable goals for the targeted behaviors andHow the staff will monitor for effectiveness of the interventions.The DON agreed with the policy and stated Resident 1's behavior of stopping and staring should have been care planned as soon as the resident's behavior was noted on 4/27/2026 so that it could potentially prevent another altercation between either him and Resident 2 or another resident. During a review of the facility's P&P titled, Abuse Prevention Program, revised December 2016, the P&P indicated, the facility's residents have the right to be free (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	from abuse. This includes but not limited to freedom from physical abuse. The P&P also indicated and as a part of the resident abuse prevention, the administration will protect the 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.