

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  555893	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  04/17/2026
NAME OF PROVIDER OR SUPPLIER  Pasadena Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE  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)
<p>F 0578</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on interview and record review, the facility failed to inform and provide written information to formulate an advanced directive (written statement of a person's wishes regarding medical treatment which were made to ensure those wishes are carried out should the person be unable to communicate them to a doctor) for two (2) of 2 sampled residents (Resident 13 and 20) reviewed for advanced directives, as indicated on the facility policy. This deficient practice had the potential to cause conflict in carrying out Resident 13 and 20's wishes for medical treatment and resident's health care decisions. Findings: 1. During a review of Resident 13's admission Record, the admission Record indicated the resident was initially admitted to the facility on [DATE] and was readmitted on [DATE] with diagnoses that included chronic kidney disease (a condition in which the kidneys are damaged and cannot filter blood as well as they should), schizophrenia (a mental illness that is characterized by disturbances in thought) and bipolar disorder (sometimes called manic-depressive disorder; mood swings that range from the lows of depression to elevated periods of emotional highs). During a review of Resident 13's Minimum Data Set (MDS- a resident assessment tool), dated [DATE], the MDS indicated Resident 13 had moderate impairment in cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decision making. The MDS also indicated Resident 13 required partial/moderate assistance (helper does less than half the effort) with shower and required supervision (helper provides cues) with toileting hygiene, oral hygiene, upper and lower body dressing, personal hygiene, sit to lying, and walking. During an attempted interview on [DATE] at 4:30 PM, the surveyor placed a call but was unable to speak with Resident 13's conservator (a person or an organization legally appointed by a court to manage the financial affairs or personal care of someone who can no longer make decisions for themselves) to verify if the facility had discussed resident's advanced directive. 2. During a review of Resident 20's admission Record, the admission Record indicated the resident was admitted on [DATE] with diagnoses that included bipolar disorder, anxiety disorder (a mental health disorder characterized by feeling of worry, or fear that are strong enough to interfere with one's daily activities) and depression (a mood disorder that causes a persistent feeling of sadness and loss of interest). During a review of Resident 20's Minimum Data Set (MDS- a resident assessment tool), dated [DATE], the MDS indicated Resident 20 had an intact cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decision making. The MDS also indicated Resident 20 was dependent with lower body dressing and putting on/taking off footwear and required substantial/maximal assistance (helper does more than half the effort) with toileting, shower and upper body dressing. The MDS further indicated Resident 20 required supervision (helper provides cues) with personal hygiene and required setup assistance (helper sets up; resident completes activity) with eating and oral hygiene. During a concurrent interview and record review of Resident 13 and 20's chart and the Electronic Medical Record (EMR, an electronic version of the resident's medical history that is maintained by the provider over time) on [DATE] at 3:12 PM, the Medical Records Director (MRD) stated there were no signed advanced directives acknowledgement forms in the chart and EMR for both Residents' 13 and 20. During a (continued on next page)</p>

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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<p>F 0578</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>concurrent interview and record review on [DATE] at 2:56 PM, the Social Services Director (SSD) stated a signed advanced directives acknowledgement form which contains information and verification that the residents were informed and provided with written information to formulate an advance directive should be in the chart in case of emergencies and placed together with the Physician Orders for Life-Sustaining Treatment (POLST - a form that contains written medical orders for healthcare professionals regarding specific medical treatments that can or cannot be done at the end-of life) so the staff are aware if the resident is a full code or Do Not Resuscitate DNR (do not resuscitate- a medical order written by a doctor to instruct health care providers NOT to do cardiopulmonary resuscitation [CPR] if breathing stops or the heart stops beating). The SSD also stated a signed advanced directive acknowledgment form should be in the chart to ensure the facility knows who to call and decide in case they no longer have the capacity to decide for themselves. During an interview on [DATE] at 3:15 PM, Registered Nurse 1 (RN 1) stated the residents' advanced directives acknowledgment forms should be in the chart in case the residents get incapacitated (unable to manage one's own affairs, care for oneself, or make decisions due to physical or mental limitations) they will be provided with the care that is expected and noted on the advanced directives acknowledgment forms. RN 1 also stated an advanced directives acknowledgement form should be in the chart to be able to identify who is the person to call that knows the resident and was aware if the residents have an advanced directive or not. During an interview on [DATE] at 9:37 AM, Director of Nursing (DON) stated advanced directives acknowledgment forms should be in the chart and should be accessible to the staff in case of emergency to ensure accurate information and care would be provided to the resident. The DON also stated there was no documented evidence through an advanced directive's acknowledgement form or documentation in the resident's progress notes that the conservator was asked if Residents 13 and 20 had an advanced directive or not or was given information about formulation of advanced directives. During a review of the facility's Policy and Procedure (P&amp;P) titled, Advanced Directives, dated [DATE], the P&amp;P indicated that if the resident does not have an advanced directive, information about whether or not the resident has executed an advanced directive, this is displayed prominently in the medical record in a section of the record that is retrievable by any staff.</p>		

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observation, interview and record review, the facility failed to provide a safe, clean and homelike environment for two (2) of four (4) sampled residents (Resident 14 and 27) reviewed for environment, as indicated on the facility's policy, when: Resident 14 was observed sitting on a bed that has no bed sheet to cover the mattress, leaving the mattress' surface exposed. Resident 27's brown pillow, which had fallen into a trashcan, was not cleaned or replaced, and was placed back to the resident's freshly made bed. The facility did not ensure no cup of juice was left by the bariatric Geri chair (a heavy duty mobile recliner with a wider seat [often 22 to 36 inches] and a higher weight capacity [typically 350 to 700 plus pounds] designed to assist plus size patients with mobility issues in transitioning from bed to a comfortable, supported sitting position) by the hallway. Facility did not ensure soiled clothing (black pant) was placed inside the laundry bin, not on the floor in the shared (Restroom A). These deficient practices had the potential to negatively impact on the safety, comfort, and quality of life of Resident 14, 27 and other residents in the facility. Findings:</p> <p>1. During a review of Resident 14's admission Record, the admission Record indicated the resident was initially admitted to the facility on [DATE] with diagnoses of depression (severe feelings of sadness and hopelessness) and schizophrenia (a chronic and severe mental disorder that affects how a person thinks, feels, and behaves).</p> <p>During a review of Resident 14'S Minimum Data Set (MDS &amp;ndash; a resident assessment tool), dated 3/24/2026, the MDS indicated the resident was moderately impaired cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decision making were moderately impaired. The MDS also indicated Resident 14 needed set up or clean up assistance (helper sets up or clean up, residents complete the activity) on eating or oral hygiene (the ability to use suitable items to clean teeth). It indicated, the resident needed supervision or touching assistance (helper provide verbal cues and provide touching / steadying and or contact guard assistance) on personal hygiene (the ability to maintain personal hygiene, including combing hair, shaving, applying makeup, washing drying face and hands).</p> <p>During a concurrent observation and interview on 4/14/2026 at 10:06 AM in Resident 14's room, Resident 14 was observed sitting on a bed without a bed sheet to cover the mattress. Resident 14 stated that his bed had been uncovered for about one and a half hours.</p> <p>During an interview on 4/16/2026 at 11:40 AM with the Certified Nursing Assistant (CNA 1), CNA 1 stated residents are not supposed to sit or lie down on a bed without a bed sheet covering it. CNA 1 also stated that the residents might feel bad if beds are not covered or not made.</p> <p>During an interview on 4/16/2026 at 11:49 AM with Resident 14, Resident 14 stated, I like it better when the bed is clean and covered; it feels more comfortable.</p> <p>2. During a review of Resident 27's admission Record, the admission Record indicated the resident was initially admitted to the facility on [DATE] with diagnoses of schizophrenia and anxiety (a feeling of nervousness, panic, and fear).</p> <p>During a review of Resident 27'S MDS, dated [DATE] the MDS indicated the resident was cognitively intact (ability to think, remember, and reason) with cognitive skills for daily decision making. Resident (continued on next page)</p>		

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>27 needed set up or clean up assistance on personal hygiene.</p> <p>During an observation on 4/14/2026 at 10:15 AM at Resident 27's room, CNA 2 was observed changing Resident 27's bed. A brown pillow fell inside the trashcan, then CNA 2 picked up the brown pillow and placed it on top of Resident 27's clean pillow.</p> <p>During an observation on 4/14/2026 at 10:27 AM in Resident 27's room, Resident 27 was observed hugging the brown pillow. Resident 27 stated that the brown pillow was a gift from the resident's mom.</p> <p>During an interview on 4/16/2026 at 11:14 AM with Resident 27, Resident 27 stated, I feel nasty; it is like hugging a pillow with shit, urine, and dump on it. Resident 27 also stated, I like everything clean.</p> <p>During an interview on 4/16/2026 at 11:23 AM with CNA 2, CNA 2 stated Resident 27's brown pillow fell into the trashcan and that she put it back on the clean bed. CNA 2 also stated, I should not have put it back on the bed; it was already dirty and could possibly cause sickness to the resident.</p> <p>During a concurrent interview and record review on 4/17/2026 at 2:21 PM with the Assistant Director of Nursing (ADON), the facility's Policy and Procedure (P&amp;P) titled Homelike Environment, revised on 1/21/2026, was reviewed. The ADON stated that the P&amp;P indicated residents are to be provided with a safe, clean, comfortable, and homelike environment. The ADON also stated that the P&amp;P for a homelike environment was not followed.</p> <p>3. During an observation on 4/14/2026 at 9:04 AM, a half full cup of cranberry juice was seen placed at the back lower metal frame of the bariatric Geri chair parked in the hallway.</p> <p>During an observation on 4/14/2026 at 9:06 AM, the Administrator (ADM) picked up the cup of juice from the Geri chair after pointing it out and stated it should not be in there.</p> <p>During an interview on 4/16/2026 at 3:22 PM, Registered Nurse 1 (RN 1) stated the cup of juice should not be left in the hallway because any of the residents who pass by the hallway can pick up and drink from it. RN 1 also stated it would not be safe for someone to accidentally drink from the cup since whoever left them could have some type of infection.</p> <p>During an interview on 4/16/2026 at 3:38 PM, the Assistant Director of Nursing (ADON) stated the staff should have removed the cup of juice from the Geri chair to ensure no residents will pick up and drink the remaining juice. ADON also stated another resident could pick up the juice and drink from it could end up getting sick or have stomach issues especially since we do not know what the other resident that left the juice has and we do not know how long it has been left on the Geri chair.</p> <p>4. During an observation on 4/14/2026 at 9:06 AM in shared Restroom A, a soiled black pant was observed on the floor inside shared restroom A.</p> <p>During an observation on 4/14/2026 at 10:14 AM in Room A, a soiled black pant was observed on the floor in Room A by bed C.</p> <p>During an observation on 4/14/2026 at 11:54 AM in shared restroom A, a soiled black pant was observed on the floor by the toilet in Restroom A. (continued on next page)</p>		

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 5/15/18, at 2:45 PM, with Certificated Nursing Assistant 1 (CNA 1), CNA 1 stated each resident has his/her laundry bin. CNA 2 stated that soiled laundry should not be left on the floor in the shared restroom or in the resident's room. Soiled laundry should be placed in the laundry bin to prevent infection or spread disease.</p> <p>During an interview on 5/15/18, at 3:05PM with ADM, ADM stated soiled laundry should be placed into the labeled laundry bin and not scattered on the floor to minimize contact, prevent the spread of germs, and avoid contaminating surfaces.</p> <p>A review of facility's policy and procedures (P&amp;P) titled, Laundry and bedding soiled dated 1/21/2026, the P&amp;P indicated that personal clothing they becomes soiled with blood or body fluid is covered or removed and immediate laundered before leaving the work area.</p>

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<p>F 0803</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident.</p> <p>Based on observation, interview, and record review, the facility failed to accurately measure the mozzarella cheese used to prepare the spinach au gratin served for lunch on 4/15/2026. This deficient practice had the potential to result in meal dissatisfaction, decreased nutritional intake, and weight loss for the 32 residents who received the spinach au gratin. Findings: During an observation on 4/15/2026 at 11:29 AM, Dietary Aide (DA 1) was observed adding mozzarella cheese to a tray of spinach without measuring it. DA 1 used her hand to add the mozzarella cheese to the tray. During an interview on 4/15/2026 at 3 PM, DA 1 stated she did not measure the mozzarella cheese added to the spinach for spinach au gratin, which was served for lunch. DA 1 stated she should have measured the mozzarella cheese to meet the requirements of a therapeutic diet (a specialized diet ordered by a physician or dietitian to manage a medical condition or health needs). During an interview on 4/15/2026 at 3:06 PM with the Dietary Service Supervisor (DSS 1), DSS1 stated that spinach au gratin was served for lunch on 4/15/2026. DSS 1 also stated 32 residents received spinach au gratin with cheese. During a concurrent interview and record review on 4/15/2026 at 3:07 PM with DSS 1, the facility's policy and procedure titled, Standardized Recipes, revised on 1/21/2026, was reviewed. DSS 1 stated that the policy indicated standardized recipes shall be developed and used in food preparation. DSS 1 also stated that the mozzarella cheese used for the spinach au gratin should have been measured.</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>Based on observation, interview, and record review, the facility failed to maintain the food service area in a clean and sanitary condition and failed to follow its proper food handling procedures to ensure food safety by failing to ensure: 1. Maintain the refrigerator with sufficient space to allow for proper internal air flow2. The can opener was not chipped along the metal blade area, and it was free from a hair-like residue from green cleaning pad. These deficient practices have the potential to result in pathogen (germ) exposure to residents, which could place the residents at risk for developing foodborne illness ([food poisoning] with symptoms including upset stomach, stomach cramps, nausea, vomiting, diarrhea, and fever) and can lead to other serious medical complications and hospitalization. Findings: During a concurrent kitchen observation and interview on 4/14/2026 at 1:05 PM, with Dietary Supervisor (DSS 1), the refrigerator has trays of sandwiches on top of gallons of milk and did not have sufficient space to allow for proper internal air flow. DSS 1 stated the refrigerator was overstocked, and the trays of sandwiches on top of gallons of milk blocks the refrigerator's vent. During a concurrent kitchen observation and interview on 4/14/2026 at 1:41 PM, with DSS 1, DSS 1 stated that the can opener has a chipped metal along the blade and had hair like residue from green cleaning pad. During an interview on 4/15/2026 at 2:55 PM, with Dietary Services [NAME] (Cook 1), [NAME] 1 stated, the refrigerator was not supposed to be overpacked due to poor air circulation which can lead to refrigerator's internal temperature not maintained, which could potentially cause food spoilage when temperatures are not maintained consistently. During an interview on 4/15/2026 at 2:56 PM, with [NAME] 1, [NAME] 1 stated the can opener should be maintained in a clean condition, and free of chipped parts, as damage to the can opener could potentially cause food contamination and illness to the residents. During a concurrent interview and record review on 4/15/2026 at 2:58 PM with the DSS 1, the facility's Policy and Procedures (P&amp;P) titled Food Receiving and Storage, revised on 1/21/2026, was reviewed. DSS 1 stated the P&amp;P indicated that foods shall be received and stored in a manner that complies with safe food handling practices. DSS 1 also stated that P&amp;P also indicated that refrigerated foods are stored in such a way that promotes adequate air circulation around the food storage containers and refrigerators/ walk-ins should not be overcrowded. DSS1 also stated the facility did not follow the P&amp;P the refrigerator was overcrowded. During a concurrent interview and record review on 4/15/2026 at 3:00 PM with DSS 1, the facility's P&amp;P titled Sanitation, revised on 1/21/2026, was reviewed. DSS 1 stated the P&amp;P indicated all utensils, counters, shelves and equipment must be clean, maintained in good repair, and are free from break, corrosions, open seams, cracks and chipped areas that may affect their use or proper cleaning. DSS1 stated the facility did not follow the P&amp;P for sanitation because the can opener was chipped with hair like residue from green cleaning pad.</p>		

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<p>F 0644</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on interviews, and record review, the facility failed to coordinate a Level II Preadmission Screening and Resident Review (PASARR, initial screening for all applicants to Medicaid-certified nursing facilities [meets federal and state standards for care and is approved to receive payment from Medicaid {a government health insurance program that provides free or low-cost coverage to eligible low-income individuals and families} for services provided to eligible residents] for possible serious mental disorder [MD, a health condition characterized by clinically significant alterations in thinking, mood, or behavior associated with distress and/or impaired functioning], intellectual disability [ID, a condition characterized by significantly subaverage intellectual functioning and substantial limitations in adaptive behavior] or a related condition, which is completed prior to admission to a nursing facility) evaluation for one (1) of three (3) sampled residents (Resident 18) reviewed for PASARR in accordance with the facility's policy. This deficient practice had the potential to result in inappropriate placement of Resident 18 and had the potential for not receiving necessary and appropriate level of treatment and evaluation in the facility. Findings: During a review of Resident 18's admission Record, the admission Record indicated Resident 18 was admitted to the facility on [DATE] with diagnoses that included schizophrenia (a mental illness that is characterized by disturbances in thought), psychosis (a severe mental condition in which thought, and emotions are so affected that contact is lost with reality) and bipolar disorder (sometimes called manic-depressive disorder; mood swings that range from the lows of depression to elevated periods of emotional highs). During a review of Resident 18's Minimum Data Set (MDS- a resident assessment tool), dated 4/2/2026, the MDS indicated Resident 18 had moderate impairment in cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decision making. The MDS also indicated Resident 18 required setup assistance (helper set up; resident completes activity) with eating and shower and was independent (resident completes the activity by themselves with no assistance from helper) with oral, toileting and personal hygiene, upper and lower body dressing, and putting on/taking off footwear. During a review of Resident 18's Medical Records the Medical Records indicated Resident 18 had a positive PASARR Level 1 screening on 4/30/2025. During a concurrent interview and record review of Resident 18's Electronic Medical Records (EMR, an electronic version of the resident's medical history that is maintained by the provider over time) on 4/15/2026 2:06 PM, the Assistant Director of Nursing (ADON) stated PASARR Level II was attempted on 5/4/2025 but was not completed because the facility staff were unresponsive to two or more separate attempts from PASARR Level II evaluator during communication within 48 hours of the PASARR Level I screening. ADON stated she was assigned to complete the PASARR Level I screenings for the residents in the facility and was the contact person for PASARR. ADON stated that the Registered Nurse Supervisor (RNS) should have taken the call from the PASARR Level II evaluator when ADON was not available to coordinate the evaluation and for Resident 18 to receive the appropriate treatment. During an interview on 4/17/2026 at 3:57 PM, the Director of Nursing (DON) stated the facility should be available to coordinate with the Level 11 PASARR evaluator to ensure the resident's behavior was being managed, followed by behavioral services, and monitored to ensure treatment was effective and the resident was appropriately placed. During a review of the facility's Policy and Procedure (P&amp;P) titled, PASARR Completion Policy, dated 1/21/2026, the P&amp;P indicated that the facility would ensure that all admissions have the appropriate PASARR completed.</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observation, interview, and record review, the facility failed to ensure the environment was free of accident hazards by placing a box fan (a square-shaped electric fan) on top of a four (4) - wheeled walker (a mobility aid with a 4 pronged base and rubber tips designed to provide more stability and support that a standard single-point cane) in the foot area of the resident's room for one (1) of three (3) sampled resident (Residents 13) reviewed for accidents, in accordance with the facility policy. This deficient practice placed Resident 13 at risk for injury and serious harm. Findings: During a review of Resident 13's admission Record, the admission Record indicated the resident was initially admitted to the facility on [DATE] and was readmitted on [DATE] with diagnoses that included unsteadiness on the feet, lack of coordination, and extrapyramidal and movement disorder (involuntary uncontrollable body movements or muscle stiffness caused by brain dysfunction). During a review of Resident 13's Minimum Data Set (MDS- a resident assessment tool), dated 3/9/2026, the MDS indicated Resident 13 had moderate impairment in cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decision making. The MDS also indicated Resident 13 required partial/moderate assistance (helper does less than half the effort) with shower and required supervision (helper provides cues) with toileting hygiene, oral hygiene, upper and lower body dressing, personal hygiene, sit to lying, and walking. During a review of Resident 13's Care Plan, revised 3/11/2026, the Care Plan indicated the resident was at risk for falls and an intervention included provide a safe environment for the resident. During an observation on 4/14/2026 at 9:50 AM in Resident 13's room, Resident 13 was seen walking back and forth to her closet, which was located near a box fan that was tilted and positioned sideways on top of a 4-wheeled walker with a seat, to get some clothes. The box fan had a taped cut-out piece of cardboard attached to the front of the fan. During a concurrent observation in Resident 13's room and interview with Certified Nursing Assistant 3 (CNA 3) on 4/14/2026 at 10:36 AM, CNA 3 verified that there was a box fan sitting sideways on top of the 4 wheeled walker with a seat in Resident 13's room. CNA3 stated the box fan should not have been placed on top of a 4 wheeled walker for safety. During an interview on 4/16/2026 at 9:33 AM, the Maintenance Service Supervisor (MSS) stated that placing a box fan on a walker was unacceptable. MSS also stated the box fan should be on the floor because the fan could fall and injure someone if placed on top of a walker. MSS further stated attaching and taping a cut-out piece of cardboard to the front of the fan could cause the fan to overheat and potentially start a fire. During an interview on 4/17/2026 at 11:35 AM, Assistant Director of Nursing (ADON) stated the cut-out piece of cardboard placed and taped to the front of the fan was a fire hazard. ADON also stated placing the fan on a walker could pose a safety risk for Resident 13 because the fan could fall and the resident could trip and fall from the fan. During a review of the facility's Policy and Procedure (P&amp;P) titled, Safety and Supervision of Residents, dated 1/21/2026, the P&amp;P indicated that the facility strives to make the environment as free from accident hazards as possible. The P&amp;P also stated that residents' safety and supervision and assistance to prevent accidents are facility-wide priorities. During a review of the facility's P&amp;P titled, Hazardous Areas, Devices, and Equipment, dated 1/21/2026, the P&amp;P indicated that all hazardous areas, devices and equipment in the facility will be identified and addressed appropriately to ensure resident safety and mitigate accident hazards to the extent possible. Examples of hazards included but are not limited to devices and equipment that are improperly used.</p>		

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<p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide enough food/fluids to maintain a resident's health.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observation, interview, and record review, the facility failed to ensure one (1) of 1 sampled resident (Resident 35) reviewed for hydration, was provided with bedside water to maintain proper hydration. This deficient practice has the potential to put the resident at risk for dehydration (a condition occurring when the body loses more fluids, primarily water). Findings: During a review of the admission Record, the admission Record indicated Resident 35 was admitted to the facility on [DATE] with diagnoses including hyperlipidemia (a condition in which there are high levels of fat particles [lipids] in the blood), hemiplegia (weakness to one side of the body), transient ischemic attack (TIA- a temporary blockage of blood flow to the brain ), and cerebral infarction (stroke - damage to the tissues in the brain due to a loss of oxygen to the area) without residual deficits. During a review of the Minimum Data Set (MDS, a resident assessment tool), dated 4/6/2026, the MDS indicated Resident 35 is assessed to be cognitively (a mental process of acquiring knowledge and understanding) moderately impaired. The MDS indicated Resident 35 required setup or clean-up assistance (helper sets up or cleans up; resident completes activity.) with eating, oral hygiene, and personal hygiene. During a review of Resident 35's Care Plan, revised 4/9/2026, the Care Plan indicated Resident 35 is at risk for Urinary Tract Infection (UTI -is a bacterial infection in the urinary system [bladder, urethra, or kidneys]) related to potential poor fluid intake, with a goal for the resident to be free from infection. The care plan interventions included offering fluids between meals, during activities, during medication pass, and during meals. During an observation and interview on 4/14/2026 at 10:02 AM, in Resident 35's room, Resident 35 was observed walking in the bathroom with an empty water pitcher. Resident 35 filled up the pitcher with tap water and drank it. Resident 35 stated neither the Certified Nurse Assistant (CNAs) and the facility staff refill the resident's water nor offer the resident with something to drink in between mealtimes. During an interview on 4/15/2026 at 09:14 AM with CNA 1, CNA 1 stated offering and refilling water between meals and as needed should be done by the facility staff for all the residents. During a concurrent observation in Resident 35's room and interview on 4/15/26 at 10:42 AM with CNA 1, CNA 1 confirmed that there was no pitcher of water at bedside available for Resident 35 to drink. During an interview on 4/15/2026 at 1:38 PM with Administrator (ADM), ADM stated tap water was not sterile and could pose risks to residents and make them sick. ADM also stated facility staff should provide adequate fluids to all residents to prevent dehydration. During a review of the facility's Policy and Procedure (P&amp;P) titled, Hydration, dated 1/21/2026, the P&amp;P indicated the physician will manage significant fluid and electrolyte imbalance and associated risks, appropriately and in a timely manner. The P&amp;P indicated for minor, uncomplicated fluid and electrolyte imbalance, oral rehydration may suffice and the staff will provide supportive measures such as supplemental fluids.</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.</p> <p>Based on observation, interview, and record review, the facility staff failed to ensure one (1) of two (2) medication carts were locked and unattended in the hallway, as indicated on the facility's policy. This deficient practice had the potential for non-authorized staff or residents to access the medication cart, which could result in diversion or if the medications were ingested, may cause serious injury/harm to the resident. Findings: During a medication pass observation on 4/16/2026 at 9:16 AM, the Licensed Vocational Nurse 1 (LVN 1) did not lock the medication cart before going to Room A to administer medications. Three (3) residents were observed walking and passing by in front of the unlocked and unattended medication cart in the hallway. During an interview on 4/16/2026 at 9:28 AM, LVN 1 stated she forgot to lock the medication cart before leaving the medication cart prior to entering Room A. LVN 1 stated residents who pass by, or other facility staff might access and take medications from the medication cart because it was unlocked and unattended. LVN 1 stated the medication cart should always be locked for the safety of the residents. During an interview on 4/16/2026 at 4:23 PM with Administrator (ADM), the ADM stated the medication cart should be kept closed, locked, and secured when it was not in use or unattended by staff. ADM stated it is not safe for residents because the residents can access the medications in the cart and consume them. During a review of the facility's policy and procedure (P&amp;P) titled, Administering Medications, dated 1/26/2026, the P&amp;P indicated that during administration of medications, the medication cart is kept closed and locked when out of sight of the medication nurse or aide.</p>		

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<p>F 0849</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observation, interview, and record review, the facility staff failed to coordinate hospice care (compassionate care for people who are near the end of life provided at the person's home or within a health care facility) with Hospice Agency for one (1) of two (2) sampled residents (Resident 18) reviewed for hospice in accordance with the facility's policy by failing to ensure Resident 18 had: 1. A physician's order of the required visits by the hospice staff (Skilled Nursing [SN], Hospice Aid [HA], Social Worker [SW], and Spiritual Care [SC]). 2. Physician certification (formal medical statement signed by a doctor confirming that a resident has a terminal illness with life expectancy of 6 months or less if the disease follows its normal course) and recertification (routine mandatory check-in that happens when a resident in hospice lives longer than the initial 6-month estimate) of the terminal illness. 3. A hospice calendar for April 2026 of the expected scheduled visits from the hospice staff. These deficient practices have the potential to result in a delay in the delivery of hospice care and services to Resident 18. Findings: During a review of Resident 18's admission Record, the admission Record indicated Resident 18 was admitted to the facility on [DATE] with diagnoses that included malignant neoplasm (an abnormal, uncontrolled growth of cells that can invade surrounding tissue and spread to other parts of the body) of maxillary sinus (cheek) and lower lobe (section) of the left lung and basal cell carcinoma (slow growing, usually curable cancer) of the skin of other parts of the face. During a review of Resident 18's Minimum Data Set (MDS- a resident assessment tool), dated 4/2/2026, the MDS indicated Resident 18 had moderate impairment in cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decision making. The MDS also indicated Resident 18 required setup assistance (helper set up; resident completes activity) with eating and shower and was independent (resident completes the activity by themselves with no assistance from helper) with oral, toileting and personal hygiene, upper and lower body dressing, and putting on/taking off footwear. During a review of the Physicians order dated 4/3/2026 at 10:44 PM, the physician's order indicated Resident 18 may be admitted to Hospice 1 (HP 1) service. During a concurrent observation in Resident 18's room and interview on 4/14/2026 1:52 PM, Resident 18 was lying in bed and stated he was unsure how often hospice staff come in to see him. During a review of Resident 18's HP 1 binder on 4/14/2026 at 2:57 PM, the resident's HP 1 binder did not include April 2026 calendar of the expected scheduled visits from the hospice staff and a Physician certification and recertification of the terminal illness. During the concurrent interview and record review with Licensed Vocational Nurse 3 (LVN 3) on 4/16/2026 at 11:34 AM, Resident 18's HP 1 binder for the month of April 2026 was reviewed. LVN 3 stated the HP 1 binder did not have the hospice order with the plan of care, the frequency of visits by the hospice interdisciplinary team (IDT, comprised of team members from different disciplines working together, with a common purpose, to set goals, make decisions, and share resources and responsibilities) and a calendar with their scheduled visits for the month of April 2026. LVN 3 also stated all this information should be in the HP 1 binder so the facility staff could coordinate Resident 18's care with hospice staff. LVN 3 also stated having the calendar will allow them to know what to follow up and when hospice staff are supposed to come. During a concurrent interview and record review with the Assistant Director of Nursing (ADON) on 4/16/2026 at 12:04 PM, Resident 18's HP 1 binder was reviewed. ADON stated there should be a physician's order with the certification of the terminal illness specific to the resident in the HP 1 binder with the plan of care including the frequency of visits by hospice IDT. The ADON also stated the HP 1 binder should have all this information to ensure the facility staff are aware of the anticipated dates of the hospice IDT visits, do a follow up if they failed to come and provide coordination and continuity of care with the facility staff for Resident 18. During an interview on 4/16/2026 at 3:07 PM, Registered Nurse 1 (RN 1) stated the physicians order with the frequency of visits by each of the HP 1 IDT should (continued on next page)</p>		

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<p>F 0849</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>be in the HP 1 binder to be able to know when they are expected to come and visit Resident 18. RN 1 stated this will ensure the resident was getting the services as ordered. RN 1 also stated if this information was not in the HP 1 binder, it could cause a lot of miscommunications and Resident 18 may not receive the hospice services timely. During an interview on 4/17/2026 at 9:31 AM, the Director of Nursing (DON) stated the schedule of the hospice IDT visit should be in the binder to ensure the care is being collaborated with the hospice and the staff at the facility. The DON also stated the HP calendar reflecting the schedule of the hospice IDT visit is important to ensure the care will be provided to the resident and the facility staff would be able to contact HP if they missed a visit and verify if they would be coming or not. During a review of the facility's Policy and Procedure (P&amp;P) titled, Hospice Program, dated 1/21/2026, the P&amp;P indicated it is the responsibility of the facility to meet the resident's personal care and nursing needs in coordination with the hospice representative, and ensure that the level of care provided is appropriately based on the individual resident's needs. The P&amp;P also indicated that the facility would obtain the following information from the hospice: The most recent hospice plan of care specific to each resident. Hospice election form. Physician certification and recertification of the terminal illness specific to each resident.</p>

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observation, interview, and record review, the facility failed to observe infection control measures for one (1) of 1 sampled resident (Residents 7) reviewed for tube feeding (a medical method of delivering liquid nutrition, fluids, and medications directly into the stomach or small intestine through a soft, flexible tube) by failing to ensure Resident 7's Gastrostomy tube (GT- tube feeding via the) was not touching the floor. This deficient practice can result in contamination of the resident's care equipment (tube feeding) and place the residents at risk of infection. During a review of Resident 7's admission Record, the admission Record indicated the resident was originally admitted to the facility on [DATE] and re-admitted on [DATE] with diagnosis that included gastrostomy (is a surgical inserting a feeding tube into the stomach, enabling direct nutrition, hydration, or medication delivery), dysphagia (difficulty swallowing food or liquid from the mouth to the stomach.), and type 2 diabetes mellitus (a condition in which the body cannot regulate blood sugar levels in the blood). During a review of Resident 7's Minimum Data Set (MDS- a resident assessment tool), dated 2/6/2026, the MDS indicated Resident 7 had moderate impairment in cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decision making. The MDS also indicated Resident 7 required substantial/maximal assistance (helper does more than half the effort) with upper/lower body dressing and was dependent (helper does all the effort) with oral hygiene, toileting hygiene, and personal hygiene. During an observation on 4/14/2026 at 9:48 AM in Resident 7's room, Resident 7's GT's feeding port (external opening of a feeding tube) was touching the floor and it does not have a cap covering the GT feeding port. During a concurrent observation on 4/14/2026 at 12:37 PM with Licensed Vocational Nurse 3 (LVN 3) in Resident 7's room, LVN 3 confirmed Resident 7's GT feeding port was touching the floor, , and missing the cap. LVN 3 picked up the GT feeding tube, wiped the GT feeding port with alcohol pad, and covered it with the cap then walked away. During an interview on 4/15/2026 at 2:19 PM with LVN 3, LVN 3 stated, any parts of the GT feeding should not be touching the floor for infection control reasons and the GT feeding port not covered with a cap and touching the floor placed Resident 7 at risk of acquiring an infection. LVN 3 stated GT should be covered with a cap when not in use. During an interview on 4/16/2026 at 12:28 PM with Infection Prevention Nurse (IPN), IPN stated uncovered GT feeding port and it was touching the floor was unacceptable. IPN state it posed an infection risk, including GI (gastrointestinal- referring to the bodily system comprising the stomach and intestines) infection such as diarrhea, nausea, and vomiting. During a review of the facility's Policy and Procedure (P&amp;P) titled, Enteral (administering nutrients or medicine directly into the GI tract) Feedings-safety Precautions, dated 1/21/2026, the P&amp;P indicated to maintain strict aseptic technique (focus on maintaining contamination free environment during procedures) at all times when working with enteral nutrition systems and formulas.</p>		

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<p>F 0883</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement policies and procedures for flu and pneumonia vaccinations.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on interview and record review, the facility failed to offer and provide Influenza (flu, a contagious respiratory illness caused by influenza viruses that infect the nose, throat, and lungs) immunization for one (1) of five (5) sampled residents (Resident 13) reviewed for infection prevention, control, and immunizations (process of protecting a person from a disease by giving a vaccine that helps the body build immunity). This deficient practice had the potential to increase Resident 13's risk of infection and suffer from severe complications such as pneumonia (lung infection), hospitalization, and death. Findings: During a review of Resident 13's admission Record, the admission Record indicated the resident was initially admitted to the facility on [DATE] and was readmitted on [DATE] with diagnoses that included disorder involving immune mechanism (body's internal security team, composed of cells, tissues, and organs that detect and destroy harmful invaders like bacteria, viruses and toxins), chronic kidney disease (a condition in which the kidneys are damaged and cannot filter blood as well as they should), and type 2 diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing). During a review of Resident 13's Minimum Data Set (MDS- a resident assessment tool), dated 3/9/2026, the MDS indicated Resident 13 had moderate impairment in cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decision making. The MDS also indicated Resident 13 required partial/moderate assistance (helper does less than half the effort) with shower and required supervision (helper provides cues) with toileting hygiene, oral hygiene, upper and lower body dressing, personal hygiene, sit to lying, and walking. The MDS indicated Resident 13 did not receive the influenza vaccine in the facility for the year's influenza season. During a concurrent interview and record review on 4/16/2026 at 3:48 PM, the influenza immunization record from 2015 - 2026 was reviewed. Infection Prevention Nurse (IPN) stated Resident 13's influenza immunization was historical which indicated Resident 13 received the immunization on 8/21/2018. IPN stated there was no influenza immunization offered to Resident 13 since admission on [DATE]. The IPN further stated it is important to offer influenza immunizations so the residents would have a chance to fight upper respiratory infections and prevent illnesses that could negatively affect their health and well-being. During an interview on 4/17/2026 at 11:24 AM, the Assistant Director of Nursing (ADON) stated influenza immunizations should be offered to the residents to ensure they are protected from flu virus. ADON added that if the residents get sick with the influenza, the residents will have milder symptoms and reduce the risk of severe illness. During a review of the facility's Policy and Procedure (P&amp;P) titled, Influenza Vaccine, dated 1/21/2026, the P&amp;P indicated that all residents who have no medical contraindications to the vaccine will be offered the influenza vaccine annually to encourage and promote the benefits associated with vaccinations against influenza. The P&amp;P also indicated that between October 1st and March 31st each year, the influenza vaccine shall be offered to residents unless the vaccine is medically contraindicated, or the resident has already been immunized</p>		

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<p>F 0887</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on interview and record review, the facility failed to offer and provide Coronavirus-19 (Covid-19, an acute respiratory illness in humans caused by coronavirus, capable of producing severe symptoms and in some cases death, especially in older people and those with underlying health conditions) immunization for one (1) of five (5) sampled residents (Resident 13) reviewed for infection prevention, control, and immunizations (process of protecting a person from a disease by giving a vaccine that helps the body build immunity) in accordance with the facility policy. This deficient practice had the potential to increase Resident 13's risk of acquiring and transmitting Covid-19 virus to other residents in the facility. Findings: During a review of Resident 13's admission Record, the admission Record indicated the resident was initially admitted to the facility on [DATE] and was readmitted on [DATE] with diagnoses that included disorder involving immune mechanism (body's internal security team, composed of cells, tissues, and organs that detect and destroy harmful invaders like bacteria, viruses and toxins), chronic kidney disease (a condition in which the kidneys are damaged and cannot filter blood as well as they should) and type 2 Diabetes Mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing). During a review of Resident 13's Minimum Data Set (MDS- a resident assessment tool), dated 3/9/2026, the MDS indicated Resident 13 had moderate impairment in cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decision making. The MDS also indicated Resident 13 required partial/moderate assistance (helper does less than half the effort) with shower and required supervision (helper provides cues) with toileting hygiene, oral hygiene, upper and lower body dressing, personal hygiene, sit to lying, and walking. The MDS indicated Resident 13 was not up to date with Covid-19 vaccination. During a concurrent interview and record review on 4/16/2026 at 3:48 PM, the Covid-19 record from 2015 to 2026 was reviewed. Infection Prevention Nurse (IPN) stated Resident 13's Covid-19 immunization was historical, which indicated Resident 13 received the immunization on 1/19/2022. IPN also stated there was no Covid-19 immunization offered to Resident 13's upon admission and till now. Resident 13 stated there were no records/documentated evidence that indicated it was offered. The IPN further stated it was important to offer Covid-19 immunizations so the residents would have a chance to fight upper respiratory infections and prevent illnesses that could negatively affect their health and well-being. During an interview on 4/17/2026 at 11:24 AM, the Assistant Director of Nursing (ADON) stated Covid-19 immunizations should be offered to the residents to ensure they are protected from the Covid-19 virus. The ADON stated if a resident, who received Covid 19 immunization, get sick with Covid-19, the resident is more likely to experience milder symptoms and a reduced risk of severe illness. During a review of the facility's Policy and Procedure (P&amp;P) titled, Coronavirus Disease (COVID-19)- Vaccination of Residents, revised 8/2025, the P&amp;P indicated that residents are offered the Covid-19 vaccine unless the immunization is medically contraindicated or the resident is fully vaccinated. The P&amp;P also indicated that residents who are eligible to receive the Covid-19 vaccine are offered the vaccine.</p>		

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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)		
<p>F 0919</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Make sure that a working call system is available in each resident's bathroom and bathing area.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observation, interview, and record review, the facility failed to ensure the call light was within resident's arm's reach for one (1) of four (4) sampled residents (Resident 2) reviewed for environment in accordance with the facility's policy. This deficient practice had the potential for Resident 2 not to be able to call the facility staff for help or assistance, especially during an emergency. Findings: During a review of Resident 2's admission Record, the admission Record indicated the resident was admitted to the facility on [DATE] and was readmitted on [DATE] with diagnoses that included unsteadiness on the feet, lack of coordination, 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 4/1/2026, the MDS indicated Resident 2 had moderate impairment in cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decision making. The MDS also indicated Resident 2 was independent (resident completes the activity by themselves with no assistance from helper) with eating, oral, toileting, and personal hygiene, shower, upper and lower body dressing and putting on/taking off footwear. During a review of Resident 2's Care Plan, initiated on 7/9/2025 and revised on 4/8/2026, the Care Plan indicated the resident was at risk for fluctuating Activities of Daily Living (ADLs- activities such as bathing, dressing and toileting a person performs daily) due to residents mood/behavior and included an intervention to ensure the resident's call light is within reach. During a review of Resident 2's Care Plan, initiated on 7/9/2025 Resident 2's Care Plan also indicated Resident 2 was at risk for fall related to poor balance from psychotropic drug (any substance that acts on the brain to change a person's mood, thoughts, feelings, or behavior) use and included an intervention to ensure the resident's call light is within reach. During a concurrent observation in Resident 2's room and interview on 4/14/2026 at 8:57 AM, Resident 2 was lying in bed watching television. Resident 2's call light was on the left side of the resident's bed, on the floor, which was confirmed by Certified Nursing Assistant 1 (CNA 1), who then clipped the call light within the resident's reach. During an observation in Resident 2's room on 4/14/2026 at 1:54 PM, Resident 2 was lying in bed with the call light not within reach. The call light was on the left side of the resident's bed on the floor. During an interview on 4/15/2026 at 12:40 PM, CNA 2 stated Resident 2's call light should be within the resident's reach so the resident could alert staff if he needed something. CNA 2 also stated that Resident 2 uses his call light to ask for assistance. During an interview on 4/16/2026 at 9:31 AM, the Assistant Director of Nursing (ADON) stated the call lights should be close to the residents' and within the residents' reach so they could call if they need something from the staff and could alert the staff for any emergencies. During a review of the facility's Policy and Procedure (P&amp;P) titled, Answering the Call Light, dated 1/21/2026, the P&amp;P indicated its purpose was to ensure timely responses to the resident's requests and needs. The P&amp;P also indicated in the general guidelines to ensure that the call light is accessible to the resident when in bed.</p>		