

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555908	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/23/2025
NAME OF PROVIDER OR SUPPLIER South Pasadena Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 904 Mission St South Pasadena, CA 91030	

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 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42223</p> <p>Based on observation, interview and record, the facility failed to provide care in a manner that maintained the resident's dignity and treated the resident with respect for one of two sampled residents (Resident 1's by failing to ensure Resident 1 was covered with a blanket/ towel when getting out of the shower.</p> <p>This deficient practice violated the resident's right for privacy and had the potential to affect the self-esteem, self-worth, sense of independence and psychosocial well-being (an individual's mental, emotional, and social health, encompassing aspects like happiness, life satisfaction, self-esteem, social functioning, and a sense of purpose, all of which are interconnected and influence overall functionality) of the resident.</p> <p>Findings:</p> <p>During a review of Resident 1's Admission Record, the Admission Record indicated the resident was admitted to the facility on [DATE] with the following diagnoses of muscle weakness and diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing).</p> <p>During a review of Resident 1's Minimum Data Set (MDS - a resident assessment tool), dated 4/8/2025, the MDS indicated the resident was independent in cognitive (the ability to understand and make decisions) skills for daily decision making. The MDS also indicated Resident 1 required partial/moderate assistance (helper does less than half the effort. Helper lifts, holds, or supports trunk or limbs, but provides less than half the effort) with oral hygiene and upper body dressing but requires substantial/maximal assistance (helper does more than half the effort. Helper lifts or holds trunk or limbs and provides more than half the effort) with toileting hygiene, shower/bathe self, lower body dressing and putting on/taking off footwear.</p> <p>During a concurrent observation and interview on 4/22/2025 at 1:46 PM, Certified Nursing Assistant 1 (CNA 1) was observed taking Resident 1 out of the shower room with a gown covering the front of Resident 1's body. Observed Resident 1's both sides of the body and back of the body exposed. CNA 1 stated Resident 1 should be fully covered when getting out from the shower not exposing the resident's both sides of the body and the resident's back to ensure resident is treated with respect and dignity. CNA 1 stated, CNA 1 did not ensure Resident 1 was fully covered when CNA 1 was transferring Resident 1 from the shower room back to the resident's room.</p> <p>(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 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 4/22/2025 at 1:50 PM, the Director of Nursing (DON) stated Resident 1 should have been covered with a poncho when being taken out of the shower room. DON also stated the poncho should have covered the whole body along with the shower chair for dignity.</p> <p>During an interview on 4/22/2025 at 2 PM, Resident 1 stated CNA 1 did not cover Resident 1 when taking the resident out of the shower and back to his room. Resident 1 stated he felt disrespected, and that CNA 1 should have put a blanket on him before taking him out of the shower room.</p> <p>During a review of the facility's Policy and Procedure (P&P) titled Resident Dignity and Personal Privacy, reviewed 4/2023, the P&P indicated examine and treat residents in a manner that maintains their privacy such as to shield the resident during all personal care and treatment procedures. The P&P also indicated to drape and dress residents appropriately to avoid exposure and embarrassment. The P&P indicated to cover resident during transfer to shower or toilet.</p>		

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<p>F 0607</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 to prevent abuse, neglect, and theft.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42223</p> <p>Based on observation, interview, and record review, the facility failed to follow their Policy and Procedure (P&P) titled Abuse (misusing something, especially mistreating a person or harming them physically) Investigation and Reporting for one of two sampled residents (Resident 1) by:</p> <ol style="list-style-type: none"> 1. Failing to report to the State Agency (SA where state law provides for jurisdiction in long-term care facilities), ombudsman (advocates for residents of nursing homes, board and care homes and assisted living facilities) and local enforcement within 2 hours after Resident 1 reported an allegation of physical abuse to Registered Nurse 1 (RN 1) on 4/22/2025 at 10 AM that Resident 2 jumped on top of Resident 1 and hit Resident 1's head. 2. Failing to separate Resident 1 and 2 immediately after the incident was reported on 4/22/2025 at 10 AM. <p>These deficient practices had potential for ongoing abuse for Resident 1 and other residents.</p> <p>Findings:</p> <p>During a review of Resident 1's Admission Record, the Admission Record indicated the resident was admitted to the facility on [DATE] with the following diagnoses of muscle weakness and diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing).</p> <p>During a review of Resident 1's Minimum Data Set (MDS - a resident assessment tool), dated 4/8/2025, the MDS indicated the resident was independent in cognitive (the ability to understand and make decisions) skills for daily decision making. The MDS also indicated Resident 1 required partial/moderate assistance (helper does less than half the effort. Helper lifts, holds, or supports trunk or limbs, but provides less than half the effort) with oral hygiene and upper body dressing but requires substantial/maximal assistance (helper does more than half the effort. Helper lifts or holds trunk or limbs and provides more than half the effort) with toileting hygiene, shower/bathe self, lower body dressing and putting on/taking off footwear.</p> <p>During a review of Resident 2's Admission Record, the Admission Record indicated the resident was admitted to the facility on [DATE] with the following diagnoses of schizophrenia (a mental illness that is characterized by disturbances in thought) and insomnia (trouble falling asleep or staying asleep).</p> <p>During a review of Resident 2's MDS, dated [DATE], the MDS indicated that the resident is independent in cognitive skills for daily decision making. The MDS also indicated the resident required supervision/touching assistance (helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity. Assistance may be provided throughout the activity or intermittently) with toileting hygiene, upper body dressing and personal hygiene but required partial/moderate assistance with shower/bathe self, lower body dressing and putting on/taking off footwear.</p> <p>(continued on next page)</p>

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<p>F 0607</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 4/22/2025 at 2 PM, Resident 1 stated Resident 2 jumped on him and hit his head (unable to recall when) and Resident 2 reported it to RN 1.</p> <p>During an interview on 4/22/2025 at 2:33 PM, RN 1 stated, on 4/22/2025 at 10 AM, Resident 1 reported that Resident 2 had jumped on Resident 1 and hit his head.</p> <p>During a concurrent observation in Resident 1 and 2's room (Room A) and interview on 4/22/2025 at 3:20 PM, Resident 1 and Resident 2 were observed in the same room. Resident 1 stated he uncomfortable being roommates with Resident 2 after Resident 2 trying to jump on Resident 1 at 10 AM.</p> <p>During an interview on 4/22/2025 at 3:30 PM, the Director of Nursing (DON) stated, RN 1 should have reported the allegation of physical abuse by Resident 2 within 2 hours after Resident 1 reported the allegation of physical abuse. The DON also stated Resident 2 jumping on Resident 1 and hitting Resident 1's head is considered a physical abuse whether it was witnessed or just an allegation of abuse it should have been reported within two hours of the incident or allegation, investigated and both resident's should have been separated immediately and changed the rooms so they are not roommates.</p> <p>During a concurrent record review of the facility's P&P titled Abuse Investigation and Reporting, revised 3/2024, and interview on 4/23/2025 at 12:30 PM, the P&P indicated all other instances of resident abuse will be reported by the facility administrator, or his/ her designee immediately or as soon as practicable but not later than two hours after the incident occurred or the allegation was made to the ombudsman, law enforcement and SA. The DON stated it should have been reported to SA, ombudsman and law enforcement but was not reported and/or investigated within 2 hours from the allegation was made. The DON also stated she was only made aware about the allegation of physical abuse by Resident 2 to Resident 1 around 3:30 PM. The DON also stated Residents 1 and 2 should have been separated to prevent further abuse, but the residents were not separated until 4/22/2025 at 3:45 PM (5 hours and 45 minutes).</p> <p>During a review of the facility's P&P titled Abuse Prevention Program dated 3/1/2024, indicated as part of the resident abuse prevention, the administration will protect the residents from abuse and protect resident during abuse investigations.</p>