STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555908	A. Building B. Wing	02/25/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
South Pasadena Care Center	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)
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to follow its policy and procedure for Changes in a Resident Condition, by failing to notify the physician on 2/7/2026 for one (1) of three (3) sampled residents (Resident 1) who had a change in condition for altered knee sensation after a witnessed fall on 2/6/2026. This deficient practice had the potential for a result in delayed provision of necessary care and services.Findings: During a record review of Resident 1's admission Record, the admission record indicated Resident 1 was initially admitted to the facility on [DATE] and readmitted on [DATE], with the diagnoses including but not limited to paraplegia (partial or complete paralysis [loss of voluntary muscle function] of the lower half of the body with involvement of both legs), pressure ulcer of sacral (bone at the end of the spine) region stage four (4) (pressure injury is very deep, reaching into muscle and bone and causing extensive damage), and osteomyelitis (infection of bones). During a record review of Resident 1's Minimum Data Set (MDS, a resident assessment and tool), dated 2/5/2026, the MDS indicated the resident's cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decision making was intact. The MDS indicated Resident 1 had impairment on both sides of the lower extremity (hip, knee, ankle, foot). The MDS indicated Resident 1 required supervision or touching assistance (helper sets up or cleans up, resident completes activity) for rolling left and left and partial/moderate assistance (helper does less than half the effort) for chair/bed-to-chair transfer. The MDS also indicated Resident 1 has not had any falls since admission. During a record review of Resident 1's SBAR (an acronym for Situation-Background-Assessment-Recommendation is a technique used to provide a framework for communication between members of the health care team), dated 2/6/2026, the SBAR indicated Resident 1 had an unavoidable witnessed fall. The SBAR indicated Resident 1 was being assisted and slipped from Certified Nursing Assistant (CNA's) grasp and slid back into the wheelchair and his left foot struck the wheelchair footrest. During a record review of Resident 1's Order Review, dated 2/6/2026, the order indicated X-ray (a type of radiation that can pass through most solid materials, is used by doctors to examine the bones or organs inside the body) ordered for foot left, toe second, hips bilateral (both sides)/pelvis (a basin-shaped structure in the human body that connects the spine to the legs). During a record review of Resident 1's Radiology Results Report, dated 2/9/2026 (3 days after the fall), the report indicated possible small avulsion fracture (a piece of bone attached to a tendon or ligament gets pulled away from the main part of the bone) of the tibial tuberosity (a bony prominence located in the knee region, playing a significant role in leg movement). During an interview on 2/24/2026 at 8:16 AM with Family Member (FM), FM stated Resident 1 had a fall when he was transferred to his wheelchair on 2/6/2026. FM stated FM visited Resident 1 about 2 days after his fall (2/8/2026) and saw Resident 1's knees were very swollen. FM stated Resident 1 had informed FM he heard a crack when he fell on his knees and had been feeling a hot burning sensation on his knees for (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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the past two days. FM stated when she asked the licensed nurse (unknown) if they did an x-ray, the licensed nurse (unknown) said they already did an x-ray on his back and foot. FM stated on 2/8/2026, FM requested the staff to contact the physician to get an order for an x-ray of Resident 1's knees. During a concurrent observation and interview on 2/24/2026 at 10:44 AM in Resident 1's room with Resident 1, Resident 1 was lying in bed with a leg brace on the right leg. Resident 1 stated he landed on both knees and heard a crack when he fell. Resident 1 stated about an hour after his fall his right leg became swollen and felt warm. Resident 1 stated the morning after his fall, he felt a burning sensation on his legs. Resident 1 stated he informed CNA 2 and CNA 3 that he felt like his legs were burning. Resident 1 stated he also informed a licensed vocational nurse (unknown) that his legs felt like they were burning. During an interview on 2/24/2026 at 3:49 PM with Certified Nursing Assistant 2 (CNA 2), CNA 2 stated Resident 1 was noncompliant with his transfer and did not hold onto CNA 2 which caused him to fall during the transfer on 2/6/2026, Resident 1's bottom was at the edge of his wheelchair, and both knees were on the floor. During an interview on 2/24/2026 at 4:13 PM with CNA 3, CNA 3 stated he saw Resident 1's knees on the floor and feet underneath the wheelchair when he entered Resident 1's room after his fall. CNA 3 stated he assisted Resident 1 onto his wheelchair. CNA 3 stated he saw redness of the upper shin of Resident 1's legs after his fall. During an interview on 2/25/2026 at 11:25 AM with Licensed Vocational Nurse 1 (LVN 1), LVN 1 stated she worked the day after Resident 1's fall (2/7/2026). LVN 1 stated on 2/7/2026 around 8:30 AM, Resident 1 informed her that due his back injury he didn't have any pain but Resident 1's knees were not how it usually felt. LVN 1 stated Resident 1 did not want his legs to be moved, and his knees felt different after his fall. LVN 1 stated she checked Resident 1's order and there was an x-ray already ordered for Resident 1's knee. LVN 1 stated if there was no x-ray order for Resident 1's knees, then she would have needed to let the physician know there was no x-ray order for Resident 1's knees. LVN 1 stated the physician needed to be informed of Resident 1's knee in case there was an injury to the area. During a concurrent interview and record review on 2/25/2026 at 11:50 AM with LVN 1 of Resident 1's Order Summary on 2/6/2026 indicated X-Ray was ordered for the foot left, toe second, and hips bilateral/pelvis. LVN 1 stated, I assumed it was for the whole leg. LVN 1 stated she should have messaged the physician and asked for the specific x-ray of the knee since Resident 1 since he complained about his knees after the fall. During a concurrent interview and record review on 2/25/2026 at 1:49 PM with the Director of Nursing (DON) of Resident 1's X-Ray Reports and SBAR, the DON stated there was an SBAR done on 2/6/2026 for Resident 1's witnessed fall. The DON stated Resident 1 is paraplegic and could not feel from the waist down. The DON stated the licensed nurses needed to assess the area and notify the physician if there was a change in condition. The DON stated the licensed nurses needed to inform the physician when Resident 1 informed staff of the burning sensation on his knees. The DON stated when Resident 1 informed the staff, the licensed nurse needed to inform the physician right after the assessment was done. The DON stated the facility needed to provide the right interventions at the right moment since the residents could easily deteriorate, especially in the elderly community. The DON also stated Resident 1 had a diagnosis of osteomyelitis making his bones more fragile and harder to heal. During a record review of the facility's policy and procedure titled, Changes in Resident Condition, dated 1/2024, the policy indicated the resident, attending physician and legal representative or designated family member are notified when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure one (1) of two (2) sampled residents (Residents 1) were provided necessary treatment and services to prevent formation of and promote healing of pressure injury (pressure ulcers, injury to the skin and underlying tissue resulting from prolonged pressure on the skin) in accordance with the resident's care plan by failing to ensure Resident 1 was repositioned every two hours. This deficient practice had the potential to place Resident 1 at risk for skin integrity complications and to have worsening or recurrence of a pressure injury. Findings: During a record review of Resident 1's admission Record, the admission record indicated Resident 1 was initially admitted to the facility on [DATE] and readmitted on [DATE], with the diagnoses including but not limited to paraplegia (partial or complete paralysis [loss of voluntary muscle function] of the lower half of the body with involvement of both legs), pressure ulcer of sacral (bone at the end of the spine) region stage four (4) (pressure injury is very deep, reaching into muscle and bone and causing extensive damage), pressure ulcer of left hip stage 4, pressure ulcer of right buttock stage 4, and pressure ulcer of left buttock stage 4. During a record review of Resident 1's Care Plan, dated 11/7/2025, the Care Plan indicated Resident 1 had impaired skin integrity as evidence by actual presence of sacrococcyx (the fused sacrum and coccyx, or tailbone) pressure injury stage 4. The staff interventions were to keep affected area clean and dry, observe for any adverse changes or complications and report to the physician immediately, and turning and repositioning every two hours or as needed. During a record review of Resident 1's Care Plan, dated 11/7/2025, the Care Plan indicated Resident 1 had impaired skin integrity as evidence by actual presence of left ischium pressure injury stage 4. The staff interventions were to keep affected area clean and dry, observe for any adverse changes or complications and report to the physician immediately, and turning and repositioning every two hours or as needed. During a record review of Resident 1's Physical Therapy Discharge summary, dated [DATE], the summary indicated Resident 1 will safely perform bed mobility tasks with contact guard assist (therapeutic technique used that involves maintaining light physical contact with a resident to ensure safety while promoting independence during mobility tasks) without use of siderails for proper sequencing and for task segmentation in order to enhance safe functional mobility . During a record review of Resident 1's Care Plan, dated 2/3/2026, the Care Plan indicated Resident 1 had impaired skin integrity as evidence by actual presence of left posterior hip pressure injury stage 4. The staff interventions were to keep affected area clean and dry, observe for any adverse changes or complications and report to the physician immediately, and turning and repositioning every two hours or as needed. During a record review of Resident 1's Minimum Data Set (MDS, a federally mandated resident assessment and tool), dated 2/5/2026, the MDS indicated the resident's cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decision making was intact. The MDS indicated Resident 1 had impairment on both sides of the lower extremity (hip, knee, ankle, foot). The MDS indicated Resident 1 required supervision or touching assistance (helper sets up or cleans up, resident completes activity) for rolling left and left. The MDS also indicated Resident 1 had stage 4 pressure ulcers. During an observation 2/24/2026 at 10:59 AM in Resident 1's room with Resident 1, Resident 1 was lying on his back. During an interview on 2/24/2026 at 1:13 PM with Treatment Nurse (TXN), TXN stated Resident 1 needed help with repositioning while awake and while asleep he would put a timer on his phone, however Resident 1 needed a lot more help now since he had a leg brace. During a concurrent observation and interview on 2/24/2026 at 2:21 PM in Resident 1's room with Resident 1, Resident 1 was lying in bed on his back and stated the staff have not offered to (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	reposition him nor assisted him with repositioning. During an interview on 2/24/2026 at 2:38 PM with Certified Nursing Assistant 1 (CNA 1), CNA 1 stated Resident 1 needed assistance with being repositioned since he could not move his legs. CNA 1 stated staff needed to carry Resident 1's legs when repositioning from the right to left side. CNA 1 stated Resident 1 was supposed to be repositioned every two hours. CNA 1 stated repositioning every 2 hours could ensure Resident 1's circulation to the areas avoided any pressure injuries and avoid current pressure injuries from worsening. CNA 1 stated CNA 1 only repositioned Resident 1 once around 9 AM during his shift (7 AM to 3 PM) and there were no other staff who had repositioned Resident 1. CNA 1 stated Resident 1 was not efficient with repositioning himself and needed assistance with carrying Resident 1's leg brace during repositioning. CNA 1 stated once repositioned, staff also needed to make sure the brace was aligned after turning. CNA 1 stated he did not do the standard procedure of repositioning Resident 1 every 2 hours during his eight-hour shift. During an interview on 2/25/2026 at 10:39 AM with the Director of Rehabilitation (DOR), DOR stated Resident 1 was paraplegic and not able to use his lower extremities. DOR stated Resident 1 was currently wearing a knee brace and could not move the knee. DOR stated a staff needed to hold the actual leg during repositioning since the brace was hard. DOR stated Resident 1's leg does have strength since he was paraplegic. During an interview on 2/25/2026 at 1:49 PM with the Director of Nursing (DON), the DON stated Resident 1 needed assistance by staff with being repositioned every 2 hours. The DON stated that staff are still required to offer repositioning to residents, even in cases where the residents decline or are noncompliant with positioning. The DON stated staff needed to reposition Resident 1 to assist with the wound to heal. The DON stated Resident 1's wounds would be at a higher risk of deterioration if Resident 1 was not repositioned. During a record review of the facility's Policy and Procedure titled, Prevention of Pressure Injuries, revised 7/12/2023, the Policy and Procedure indicated reposition resident as indicated on the care plan.