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	06/18/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
South Pasadena Care Center	904 Mission St South Pasadena, CA 91030

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review, the facility failed to implement a comprehensive person-centered care plan for Gastrostomy tube (G-tube, is a tube that is placed directly into the stomach through an abdominal wall incision for administration of food, fluids, and medications) by not having a documented evidence to monitor his G-tube site for one (1) of 2 sampled residents (Resident 2) as indicated on the facility's policy. This deficient practice had the potential for Resident 2 not to receive the proper care and treatment if the medications and nutrition were not administered timely through his G-tube site, which also may result in hospitalization, injury and harm. Findings:During a review of Resident 2's admission Record, the admission record indicated Resident 2 was admitted to the facility on [DATE] and readmitted [DATE]. Resident 2's diagnoses included hemiplegia (paralysis of one side of the body) hemiparesis (weakness on one side of the body) cerebral infarction (refers to damage to tissues in the brain due to a loss of oxygen to the area) affecting right dominant side, dysphagia (difficulty swallowing), Diabetes mellitus (DM, is a metabolic disease, involving inappropriately elevated blood glucose levels), and metabolic encephalopathy (an alteration of brain function or consciousness due to failure of other internal organs) During a review of Resident 2's Minimum Data Set (MDS, a resident assessment tool), dated 5/3/2026, the MDS indicated Resident 2 has severely impaired cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decision making. The MDS indicated Resident 2 was dependent (helper does all of the effort, resident does none of the effort to complete the activity) in eating, toileting hygiene, shower/ bathe self, lower body dressing, putting on/ taking off footwear, roll left and right, sit to lying, lying to sitting on side of bed and tub/ shower transfer.During a record review of Resident 2's Physician's Order (PO) dated 7/22/2025, the PO indicated Check G-tube patency and placement every shift.During a record review of Resident 2's Situation, Background, Assessment, Recommendation (SBAR, is a verbal or written communication tool that helps provide essential, concise information, usually during crucial situation) dated 8/3/2025 to 9/17/2025 was reviewed. The SBAR indicated,1.On 8/3/2025, Resident 2's G-tube was dislodged; however, Resident 2's abdominal binder was in place. Upon assessment, the binder remained intact and the GT was found with the balloon still inflated. Examination of the stoma revealed that it had already closed.2.On 8/11/2025, Resident 2's G-tube was dislodged, abdominal binder was in place. Resident 2 pulled at the G-tube connection for the Tube Feeding machine (enteral feeding pump, delivers liquid nutrition /formula directly into the stomach or small intestine via a feeding tube).3.On 8/30/2025, Resident 2's G-tube was dislodged, and the abdominal binder was in place. Resident 2 pulled the G-tube connection for the Tube Feeding machine. The G-tube balloon was intact, and an indwelling catheter was inserted on the stoma to keep it open.4.On 9/5/2025, Resident 2's G-tube was dislodged, and the abdominal binder was in place. Resident 2 pulled the G-tube connection from the Tube Feeding machine. The G-tube balloon was intact; an indwelling catheter was inserted on the stoma to keep Resident 2's gastrostomy stoma open.5.On 9/17/2025, Resident 2's G-tube was dislodged during Activities of Daily Living (ADLs, are activities related to personal care including bathing or showering, dressing, getting in and out of bed (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	or a chair, walking, using the toilet, and eating) with the Certified Nursing Assistant (CNA). The G-tube balloon was intact. Resident 2's abdominal binder was open. Indwelling catheter was inserted to keep Resident 2's gastrostomy stoma open. Physician ordered to transfer Resident 2 to hospital for G-tube reinsertion. During a record review of Resident 2's Nurses' Progress Notes (NPN) dated 8/3/2025 to 9/17/2025 was reviewed. The NPN indicated that there was no documentation from the licensed staff regarding Resident 2's G-tube dislodgement between 8/11/2025 to 9/17/2025. During a review of Resident 2's Care Plan (CP) for episodes of pulling out his G-tube revised 3/12/2026, the CP interventions indicated the following: Use a draw sheet or lifting device to move the Resident Use caution during transfers and bed mobility to prevent striking arms, legs, and hands against any sharp or hard surface. Weekly treatment documentation During a review of Resident 2's CP for dependent on tube feeding for all nutrition and hydration initiated 3/12/2026, the CP indicated, Check G-tube site dressing every shift and as needed (PRN) for soilage, leakage or staining. Check residuals every shift and hold tube feeding if residual is above 100 milliliters (ml, unit of measurement) Check G-tube placement or patency every shift Cleanse G-tube site daily and PRN for soilage, leakage or staining. May have abdominal binder to prevent G-tube pull out During a review of Resident 2's CP for aggressive behavior towards staff and attempting to pull his G- tube initiated 3/12/2026, the CP indicated, Will apply abdominal binder to prevent G-tube dislodgement Will continue to provide safe environment for the Resident Will encourage the resident to vent out his feelings During a concurrent interview and record review on 6/18/2026 at 10:05 AM with Licensed Vocational Nurse 1 (LVN 1), Resident 2's CP for aggressive behavior towards staff and attempting to pull his G- tube initiated 3/12/2026 was reviewed. LVN 1 stated The CP had incomplete interventions. They need to add more interventions to prevent Resident 2's G-tube dislodgement. They should add monitoring for Resident 2's abdominal binder should be in place all the time. The staff should keep the G-tube out of Resident 2's reach. During a concurrent interview and record review on 6/18/2026 at 10:39 AM with LVN 3, Resident 2's CP for aggressive behavior towards staff and attempting to pull his G- tube initiated 3/12/2026 was reviewed. LVN 3 stated the CP interventions were too short. They should add more interventions, like approach Resident 2 calmly because Resident had aggressive behavior and staff should check Resident 2's abdominal binder more frequently. The staff should have consistent rounds which should be done every 2 hours to make sure Resident 2 was not pulling his G-tube. During a concurrent interview and record review on 6/18/2026 at 11:17 AM with LVN 2, Resident 2's SBAR dated 8/3/2025 to 9/17/2025 was reviewed. The SBAR indicated Resident 2 had G-tube dislodgement. LVN 2 stated that was a lot of G-tube dislodgement for Resident 2. Resident 2 was aggressive. Resident 2's non-affected hand was very strong and can reach the G-tube and will pull on it. During a concurrent interview and record review on 6/18/2026 at 11:32 AM with LVN 2, Resident 2's Treatment Administration Record dated 8/1/2025 to 8/31/2025 was reviewed. LVN 2 stated Resident 2's TAR indicated Resident 2 dressing change for his G-Tube. The staff should include checking Resident 2's abdominal binder in the Medication Administration Record (MAR, is a report detailing the drugs administered to a resident by a healthcare professional at a treatment facility), Change of Condition (COC, is a sudden clinically important deviation from a resident's baseline in physical, cognitive, behavioral, or functional domains) or SBAR documentation. If there was no documentation from the staff, it means it did not happen, and there was no abdominal binder on the Resident. LVN 2 also stated it means that no one was checking or monitoring Resident 2's abdominal binder and his behavior of pulling his G-tube. During a concurrent interview and record review on 6/18/2026 at 1:48 PM with the Director of Nursing (DON), Resident 2's SBAR dated 8/3/2025 to 9/17/2025 was reviewed. The SBAR indicated Resident 2 had episodes of G-tube dislodgement. DON stated Resident 2 had 5 episodes of pulling his G-tube, that was a lot. Resident 2 was pulling his G-tube tubing from his Tube Feeding machine; there were 2 episodes that he dropped the G-tube set up on the floor. During a concurrent interview and record review on 6/18/2026 at 1:58 PM with the DON, Resident 2's CP for aggressive behavior towards staff and attempting to pull his G- tube (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	initiated 3/12/2026 was reviewed. DON stated the CP interventions were not enough, it was very limited. The CP should have redirected Resident 2 not pulled on his G- tube. They need to put a towel and hide the G-Tube. They need to tuck Resident 2's G-tube on the opposite side of the dominant hand where Resident 2 would not be able to reach it. Monitoring Resident 2 frequently every shift could have prevented him from pulling his G-tube. They could have prevented the G-tube dislodgement if the facility did conduct close monitoring or 1:1 supervision for Resident 2 after the first episode of dislodgement. During an interview on 6/18/2026 at 2:04 PM with the DON, DON stated when staff monitor Resident 2, the staff should have to document on the Nurse's Progress Notes (NPN). If the licensed staff did not document any monitoring, it means they did follow Resident 2's care plan. During a concurrent interview and record revie on 6/18/2026 at 2:46 PM with DON, the facility's policy and procedure (P&P) titled, Care Plan- Comprehensive Person- Centered, revised on 1/2025, the P&P indicated each resident comprehensive care plan has been designated to incorporate identified problem areas, and incorporate risk factors associated with identified problems. DON stated they did not follow the policy; they could have addressed the problem for Resident 2. During a review of the facility's P&P titled, Changes in Resident Condition revised 1/2024, The P& P indicated,3.Changes in condition are communicated from shift to shift through the 24-hour report management system.4.Changes in the resident status that affect the problem(s)/goal(s) or approach(es) on his/her care plan are documented as revisions and communicated to the interdisciplinary caregivers

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide necessary daily needs and care to ensure quality of care was provided, residents' wellbeing was cared for and prevent the possible harm and illness due to Activities of Daily Living (ADL) not being provided for one (1) of two (2) sampled residents (Resident 1). These deficient practices have potentially led to residents do not have quality of life and the harm and illness that might cause due to ADL were not provided. During a review of Resident 1's admission Record, the admission Record indicated Resident 1 was initially admitted to the facility on [DATE] and readmitted to the facility on [DATE]. Resident 1's diagnoses including but not limited to metabolic encephalopathy (a syndrome of global brain dysfunction caused by an underlying systemic illness rather than a direct physical injury to the brain), hemiplegia (a severe or complete loss of strength or paralysis on one side of the body) and hemiparesis (a mild loss of strength in a leg, arm, or face) following cerebral infarction (a damage to tissues in the brain due to a loss of oxygen to the area) affecting left non-dominant side and dysphagia oropharyngeal phase (difficulty moving food and liquids from the mouth into the throat and esophagus). During a review of Resident 1's Minimum Data Set (MDS, a resident assessment tool), dated 5/6/2026, the MDS indicated Resident 1 had moderate impairment (decisions poor, cues/supervision required) for cognitive skills (the mental processes that allow people to think, learn, and solve problems) for daily decision making. The MDS indicated Resident 1 was dependent, (helper does all the effort) with the oral hygiene, toileting hygiene, shower/bath self, upper and lower body dressing, putting on/ taking off footwear, personal hygiene, roll left and right and sit to lying. During a concurrent observation and interview on 6/17/2026 at 9:35 AM with the Certified Nursing Assistant 1 (CNA 1) in Resident 1's room, observed there were scrape wounds (an injury where the top layers of skin are rubbed or torn off) on Resident 1's right shoulder and her right thigh. CNA 1 stated she did not know how these wounds happened, they were there when she came back to work after the past weekend. During a concurrent observation and interview on 6/17/2026 at 10:15 AM with the Licensed Vocational Nurse 1 (LVN 1) in Resident 1's room, LVN 1 stated per the weekend wound care nurse LVN 2's report, Resident 1's scrape on her right shoulder and right thigh were self-inflicted scratch wounds (a physical injury a person causes to their own skin, often using fingernails, sharp objects, or abrasive materials) it was happened on 6/14/2026 near 2 PM. The Situation, Background, Assessment, and Recommendation (SBAR, a standardized, highly structured communication framework primarily used in healthcare settings to quickly and clearly convey crucial patient information) report was sent to MD. LVN 1 stated she did not witness Resident 1's skin injury when it happened. During an interview on 6/17/2026 at 4:45 PM with the Registered Nurse Supervisor (RNS), RNS stated she got a report from the LVN 2 that Resident 1 scratched herself to her right shoulder and right thigh on 6/14/2026 at 4 PM, she cut Resident 1's nails after physician was notified and wound care had performed by LVN 2. During an interview on 6/18/2026 at 7:45 AM with LVN 2, LVN 2 stated CNA 2 reported Resident 1's scratches on her right shoulder and right thigh. LVN 2 stated he did not witness Resident 1 scratched wound. LVN 2 stated he reported the incident to DON, called physician, obtained order from physician and provided wound care to Resident 1 per physician's order. During an interview on 6/18/2026 at 10:12 AM with LVN 1, LVN 1 stated the self-inflicted scratch from Resident 1's right upper shoulder skin may be from the sheets, but she saw Resident 1 has been scratching herself on her right thigh. LVN 1 also stated that she saw Resident 1's fingernails were long enough to hurt herself last week, LVN 1 stated she told CNAs to cut Resident 1's nails and cover Resident 1 skin with sheet to prevent her from touching her skin, but I did not check if CNA cut Resident 1's nail. During an interview on 6/18/2026 at 12:42 PM with the Director of Nursing (DON), DON stated there were no specific nursing staffs to cut and trim the nails for the residents. DON stated CNAs, LVNs and RNSs can cut and trim resident's' nails. DON also stated there was no specific policy for nail (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	cutting and trimming for the residents. DON stated the facility uses Resident Dignity and Personal Privacy as a guide for nail cutting and trimming. During a review of the facility's Policy and Procedure (P&P) titled, Resident Dignity and Personal Privacy, reviewed on April 2025, the P&P indicated:Care for residents in a manner that maintains dignity and individuality:Groom appropriately and to resident desire. During a review of the facility's P&P titled, Activities of Daily Living (ADLs), Supporting, reviewed on April 2023, the P&P indicated: Residents who are unable to carry out activities of daily living independently will receive the services necessary to maintain good nutrition, grooming and personal and oral hygiene. Appropriate care and services will be provided for residents who are unable to carry out ADLs independently, with the consent of the resident and in accordance with the plan of care, including appropriate suppo1t and assistance with: hygiene (bathing dressing, grooming, and oral care).