

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 03/17/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555119	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/21/2025
NAME OF PROVIDER OR SUPPLIER Saint Vincent Healthcare		STREET ADDRESS, CITY, STATE, ZIP CODE 1810 N. Fair Oaks Ave Pasadena, CA 91103	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. (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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and review, the facility failed to provide care in a manner that maintained a resident's dignity and respect for three of three sampled residents (Residents 3, 57, and 65) under dignity care area by failing to ensure facility staff were at eye level while assisting the residents during meals. This deficient practice had the potential to affect Resident 3, 57, and 65's self-esteem and self-worth. 1. During a review of Resident 3's admission Record, the admission Record indicated Resident 3 was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included protein calorie malnutrition (a nutritional disorder caused by a deficiency of both protein [nutrient essential for building and repairing tissues like muscles and organs] and calories [unit of energy, and in nutrition measures the amount of energy the body gets from food and drinks] resulting in depletion of body fat and muscle mass, fatigue and increased susceptibility to illness, muscle weakness (loss of muscle strength), dementia (loss of brain function including memory, thinking and social abilities severe enough to interfere with daily life), and major depressive disorder (mood disorder characterized by feelings of sadness and loss of interest that interfere with daily life). During a review of Resident 3's Minimum Data Set (MDS-a resident assessment tool), dated 10/28/2025, the MDS indicated Resident 3 had severely impaired cognitive (ability to think, learn, remember and reason) skills for daily decision making. The MDS indicated Resident 3 required partial/moderate assistance (Helper lifts, holds, or supports trunk or limbs, but provides less than half the effort) with eating. Resident 3 required substantial/maximal assistance (Helper lifts or holds trunk or limbs and provides more than half the effort) with oral hygiene and upper body dressing and was dependent (Helper does all the effort. Resident does none of the effort to complete the activity or, the assistance of two or more helpers is required for the resident to complete the activity) with toileting hygiene, lower body dressing, and putting on/taking off footwear. During an observation in Resident 3's room on 11/18/2025 at 12:39, Certified Nurse's Aide 1 (CNA 1) was observed talking to Resident 3 who had stopped eating her food. CNA 1 was then observed feeding Resident 3 while standing. CNA 1 was not within eye level of Resident 3. 2. During a review of Resident 57's admission Record, the admission Record indicated Resident 57 was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included protein calorie malnutrition, dysphagia (difficulty swallowing foods or liquids easily and comfortably), dementia with psychotic disturbance (condition where a person experiencing significant cognitive decline also has symptoms of psychosis which involves losing touch with reality), and schizoaffective disorder (a mental health condition that combines symptoms of both schizophrenia [hallucinations or delusions] and a mood disorder (such as depression or mania [mood episode characterized by abnormally elevated or irritable mood, increased energy, and activity])). During a review of Resident 57's MDS, dated [DATE], the MDS indicated Resident 57 had severely impaired cognitive skills for daily decision making. The MDS indicated Resident 57 required partial/moderate assistance with eating. The MDS indicated Resident 57 required substantial/maximal assistance with upper body dressing and was dependent with oral, toileting and personal hygiene, showering/bathing self, lower body dressing, and putting on/taking off footwear. During an observation in Resident 57's room on 11/18/2025 at 12:33 PM, CNA 1 was observed assisting Resident 57 with eating lunch while sitting on a bar stool (tall chair designed to be used at a bar or high table). Resident 57's bed was in the lowest position. CNA 1 was not within eye level with Resident 57 while assisting the resident with eating her meal. 3. During a review of Resident 65's admission Record, the admission Record indicated Resident 65 was admitted to the facility on [DATE] with diagnoses that included vitamin D deficiency (body has inadequate levels of vitamin D which can lead to serious health problems like brittle bones and muscle weakness), dementia with mood disturbance, and major depressive disorder. During a review of Resident 65's MDS, dated [DATE], the MDS indicated Resident 65 had severely impaired cognitive skills for daily decision making. The MDS indicated Resident 65 required partial/moderate assistance with eating and was dependent with oral, toileting, and personal hygiene, showering/bathing self, upper and lower body dressing, and putting on/taking off footwear. During an observation in Resident 65's room on 11/18/2025 at 12:25 PM, CNA 2 was observed assisting Resident 65 with eating lunch while sitting on a bar stool. Resident 65's bed was in the lowest position. CNA 2 was not within eye level with Resident 65 while assisting the resident with eating her meal. During a concurrent observation in Residents 57 and 65's room and interview with CNA 3 on 11/18/2025 at 12:45 PM, CNA 3 confirmed CNA 1 and CNA 2 were not within eye level of Residents 57 and 65 while assisting the residents		

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility staff failed to provide privacy and confidentiality (safeguarding the content of information from unauthorized disclosure without the consent of the Resident and/or the individual's surrogate or representative) for one of 18 sampled residents (Resident 48) when Resident 48's name, room number, and post-op wound care instructions were left posted outside the residents room. This deficient practice violated Resident 48's right to privacy and confidentiality. Findings: During a review of Resident 48's admission Record, the admission Record indicated Resident 48 was admitted to the facility on [DATE] with diagnoses that included unspecified atrial fibrillation (irregular heart rhythm where the upper chambers of the heart beat chaotically and out of sync with the lower chambers), unspecified glaucoma (increased eye pressure that lead to permanent vision loss and blindness) and unspecified macular degeneration (damage to the center of the eye). During a review of Resident 48's Minimum Data Set (MDS- a resident assessment tool), dated 6/3/2025, it indicated Resident 48 was assessed having moderately impaired cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decision making. The MDS also indicated Resident 48 required supervision or touching assistance with eating, oral hygiene, and upper body dressing. It indicated Resident 48 required partial/moderate assistance with toileting hygiene, personal hygiene, lower body dressing, shower/bathe self, rolling left and right sit to stand, toilet transfer, and walking 10 feet (ft-unit of measurement for length). During a review of Resident 48's Order Summary Report, dated 11/21/2025, the Order Summary Report indicated the following physician order, with a start date of 11/17/2025: Post-operative (post-op) wound care instructions for closed wound:1. Avoid strenuous exercise or activity (bending, stooping, lifting heavy objects greater than 10 pounds) that could harm to the wound for at least three weeks until (12/8/25).2. Avoid lying or sleeping on the side where surgery was performed. During an observation outside Resident 48's room, on 11/18/2025, at 9:36 AM, one sheet of paper with Resident 48's name, room number and post-op wound care instructions was observed posted outside Resident 48's room. During an interview on 11/19/2025, at 3:13 PM, with Registered Nurse Supervisor 1 (RNS 1), RNS 1 stated Resident 48 had surgery performed on the resident's left hand on 11/17/2025. RNS 1 stated Resident 48's post-op wound care instructions were confidential and should not have been posted outside Resident 48's door. RNS 1 stated Resident 48's post-op wound care instructions should have been filed in his chart. RNS 1 stated Resident 48's wound care instructions should only be given to staff providing direct care to Resident 48. RNS 1 stated posting Resident 48's wound care instructions outside the resident's door allowed everyone in the facility to have access to the resident's private information. RNS 1 stated it was Resident 48's right to have his information kept private and the resident or family member did not request to post the confidential information outside the resident's door. RNS 1 stated the facility's policy for privacy and confidentiality was not followed. During an interview on 11/21/2025, at 4:01 PM with the Director of Nursing (DON), the DON stated residents' information should be protected and kept confidential. The DON stated the facility staff should not post resident information in a place where it can be seen by visitors or staff not directly involved with the residents' care. The DON stated the residents have the right to privacy and confidentiality. During a review of the facility's policy and procedure (P&P), titled, Dignity, revised 2/2021, the P&P indicated, Staff protect confidential clinical information. Signs indicating the Resident's clinical status or care needs are not openly posted in the Resident's room unless specifically requested by the Resident or family member.		

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, and record review, the facility failed to complete a Preadmission Screening and Resident Review (PASRR), a federal requirement to help ensure that every resident entering a Medicaid Certified Nursing Facility [NF] receives a Level I screening and if necessary a Level II Evaluation to ensure that the NF residence is appropriate and to identify what specialized services the resident may need) for one (1) of two (2) sampled residents (Resident 4) under PASRR care area, in accordance with the facility's policy. This deficient practice had the potential to result in inappropriate placement of Resident 4 and had the potential for not receiving the necessary and appropriate level of treatment and evaluation in the facility. Findings: During a review of Resident 4'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 major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest) 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 4's Minimum Data Set (MDS- a resident assessment tool), dated 10/1/2025, the MDS indicated Resident 4 had severe impairment in cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decision making. The MDS also indicated Resident 4 required partial/moderate assistance (helper does less than half the effort) with toileting, shower, lower body dressing and putting on/taking off footwear and required supervision (helper provides cues) oral and personal hygiene and upper body dressing. The MDS further indicated Resident 4 required setup assistance (helper sets up; resident completes activity) with eating. During an interview on 11/20/2025 at 4:16 PM, the Director of Nursing (DON) stated there should be a new PASRR 1 upon re-admission on [DATE] due to Resident 4's new diagnosis of major depressive and anxiety disorder. The DON also stated there was no PASRR 1 completed. The DON stated the admission personnel were responsible for making sure there was a file exchange from the general acute care hospital (GACH) and that the PASRR website was checked if a PASRR was downloaded. The DON further stated completing a PASRR 1 screening was important to ensure there was appropriate screening for the resident's placement, delivery of care, and to determine if further recommendations were needed. The DON stated if there was no PASRR 1, the resident might not be appropriately placed in the facility and not receive appropriate interventions. During an interview on 11/21/2025 at 9:05 AM, Registered Nurse 2 (RNS 2) stated the licensed staff should have checked Resident 4's medical records to see if there was a PASRR done from GACH for resident's mental and developmental issues and other related issues. During a concurrent interview and record review of the PASRR policy with the DON on 11/21/2025 at 9:54 AM, the DON stated that a new PASRR 1 should be done if there was a change in the residents' mental condition such as depression and anxiety and no diagnosis of that mental condition on the residents' original admission. During a review of the facility's undated policy and procedure titled, Preadmission Screening and Resident Review Reports (PASRR), revised 11/30/2023, the policy and procedure indicated that when a resident is newly admitted to the facility after a hospital stay, the facility staff will review the hospital completed PASRR. If the facility finds significant change since hospital PASRR completed, a resident review will be completed.		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews, and record review, the facility failed to ensure one (1) of 1 sampled resident (Resident 4) received monitoring and care for the left eye redness as indicated on the care plan and in accordance with the facility's policy. This deficient practice had the potential to negatively affect Resident 4's physical comfort and well-being caused by delay in receiving necessary treatment. Findings: During a review of Resident 4'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 cicatricial ectropion of left eye (a condition where the lower eyelid turns outward). During a review of Resident 4's Minimum Data Set (MDS- a resident assessment tool), dated 10/1/2025, the MDS indicated Resident 4 had severe impairment in cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decision making. The MDS also indicated Resident 4 required partial/moderate assistance (helper does less than half the effort) with toileting, shower, lower body dressing and putting on/taking off footwear and required supervision (helper provides cues) oral and personal hygiene and upper body dressing. The MDS further indicated Resident 4 required setup assistance (helper sets up; resident completes activity) with eating. During a review of Resident 4's Care Plan revised on 10/12/2025, the Care Plan indicated Resident 4 was at risk for eye redness/irritation and infection with an approach plan to notify Medical Doctor (MD) for signs and symptoms of eye infection which included redness. During an observation in Resident 4's room on 11/18/2025 at 9:54 AM, Resident 4 was lying in bed and observed to have redness on the left lower eyelid. During an interview on 11/20/2025 at 12:35 PM, the MDS Nurse (MDSN) stated the facility staff should monitor and notify MD for Resident 4's left eye redness to prevent the condition from getting worse. During a concurrent record review and interview with Registered Nurse 2 (RNS 2) on 11/20/2025 at 12:51 PM, the nurses progress notes were reviewed. RNS 2 stated there was no documentation of monitoring for left eye redness in the nurses' progress notes. RNS 2 stated there should be monitoring on Resident 4's left eye redness to prevent complications and to ensure that the care plan interventions were being implemented. During an interview on 11/20/2025 at 3:23 PM, Assistant Activity Staff (AAS) stated he had noticed Resident 4's left eye was red a couple of days ago, on 11/18/2025, while in the activity room and had thought the resident was already getting treatment for it so he did not notify any of the staff. During an interview on 11/20/2025 at 3:36 PM, the Activity Director (AD) stated she did not notify any of the nursing staff since she had noticed Resident 4's left eye had always been red and thought the nursing staff was aware. AD also stated she should have reported her observation to the nursing staff so Resident 4's MD will be notified. During an interview on 11/21/2025 at 8:38 AM, the Director of Nursing (DON) stated the nursing staff should follow Resident 4's care plan intervention on monitoring the resident's left eye for redness to prevent development of infection. The DON also stated the facility staff should not assume that there was already treatment given to Resident 4's left eye and should report to the nursing staff their observation. During a review of the facility's Policy and Procedure (P&P) titled, Care Plans, Comprehensive Person-Centered revised 3/2022, the P&P indicated that a comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident.		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (continued on next page)		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide the necessary care and intervention to prevent accidents or injury for three (3) of five (5) sample residents (Resident 4 and 20) under the Accidents care area in accordance with the facility's policy and procedure when: 1. The facility did not ensure Residents 4 was not in the room while the housekeeping was mopping the floor on 11/18/2025. 2. The facility did not ensure Resident 20 was not in the room while housekeeping was mopping the floor on 11/18/2025 and was reoriented and redirected back to her room while wandering (to move around different places usually without having a particular purpose or direction) on 11/20/2025 and 11/21/2025. These deficient practices placed Resident 4 and 20 at risk for accident and/ or injury. Findings: 1. During a review of Resident 4'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 lack of coordination (unsteadiness) and history of fall. During a review of Resident 4's Minimum Data Set (MDS- a resident assessment tool), dated 10/1/2025, the MDS indicated Resident 4 had severe impairment in cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decision making. The MDS also indicated Resident 4 required partial/moderate assistance (helper does less than half the effort) with toileting, shower, lower body dressing and putting on/taking off footwear and required supervision (helper provides cues) oral and personal hygiene and upper body dressing. The MDS further indicated Resident 4 required setup assistance (helper sets up; resident completes activity) with eating. During a review of Resident 4's Care Plan revised on 9/2025, it indicated Resident 4 was at risk for falls related to poor safety awareness and history of fall with an approach plan of ensuring to keep environment free of hazards and maintain a safe environment at all times. 2. During a review of Resident 20's admission Record, the admission Record indicated the resident was admitted to the facility on [DATE] with diagnoses that included muscle weakness, abnormalities in gait (the manner or pattern of how someone walks, runs, or moves on foot) and mobility, and dementia (a progressive state of decline in mental abilities). During a review of Resident 20's MDS dated [DATE], the MDS indicated Resident 20 had moderate impairment in cognitive skills for daily decision making. The MDS also indicated Resident 20 required partial/moderate assistance with shower and required supervision with oral, toileting, and personal hygiene, upper and lower body dressing and putting on/taking off footwear. The MDS further indicated Resident 20 required setup assistance with eating. During a review of Resident 20's Care Plan revised on 9/2025, it indicated Resident 20 was at risk for falls related to poor safety awareness and mobility with an approach plan of ensuring to keep Resident 20's environment free of hazards and maintain a safe environment at all times. During a review of Resident 20's Care Plan revised on 9/2025, it indicated Resident 20 was at risk for wandering and elopement (the act of leaving a facility unsupervised and without prior authorization) with an approach plan to gently redirect the resident back to supervised areas. During an observation on 11/18/2025 at 9:41 AM, Facility Housekeeping was observed mopping the floor in Resident 4 and 20's room (Room A) while both residents were in bed with a wet floor precaution sign placed by the door. During an interview on 11/19/2025 at 4:21 PM, Quality Assurance Nurse (QAN) stated residents should not be in the room while housekeeping is mopping the floor/ after mopping the floor because wet floor placed the resident in that room at risk for accidents such as slip and fall. During an interview on 11/20/2025 at 11:59 AM, the Housekeeping Supervisor (HKS), the HKS stated housekeeping should ensure residents are not in the room before mopping to prevent the resident from slipping on wet floor. HKS also stated the housekeeper should not have mopped the floor when there are residents in the room to prevent fall or accident, instead the housekeeper should have skipped and went to another empty room. During an observation on 11/20/2025 at 4:15 PM, Resident 20 was seen wandering in other residents' room (Room B) without staff following and redirecting the resident. During an observation on 11/21/2025 at 1:00 PM, Resident 20 was seen going inside the DON's office where State Agency (SA) surveyors were without any facility staff close by to redirect the resident. During a concurrent interview and record review on 11/21/2025 at 1:35 PM, Resident 20's wandering assessment was reviewed. Registered Nurse Supervisor 2 (RNS 2) stated Resident 20's was high risk for elopement RNS 2 also stated the facility staff should reorient, provide diversion, and guide Resident 20 back to the resident's room for the resident's safety. During an interview on 11/21/2025 at 1:41 PM, the DON stated the facility staff should be redirecting Resident 20 when they see residents wandering around		

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. (continued on next page)		

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide the necessary services to one of one sampled resident (Resident 5) who requires dialysis (the medical necessity for ongoing removal of waste and excess fluid from the blood to sustain life due to permanent kidney failure) by failing to accurately monitor the resident's fluid intake and to follow the physician's order for fluid restriction of 1000 milliliters (ml- unit of measurement for volume) a day. This deficient practice had the potential to place Resident 5 at risk for fluid overload recurrence. Findings: During a review of Resident 5's admission Record, the admission Record indicated Resident 5 was admitted to the facility on [DATE] and was readmitted on [DATE] with diagnoses that included end stage renal disease (condition where the kidneys have permanently stopped working and can no longer function at a level needed to sustain life), acute respiratory failure with hypoxia (condition where the body cannot get enough oxygen in the blood), dependence on renal (kidneys) dialysis, and pleural effusion (accumulation of excess fluid in the area between the lungs and the chest wall). During a review of Resident 5's Minimum Data Set (MDS- a resident assessment tool), dated 9/14/2025, the MDS indicated Resident 5 was assessed having moderately impaired cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decision making. Resident 5 required setup or clean-up assistance with eating and oral hygiene. Resident 5 required supervision or touching assistance with upper body dressing and personal hygiene. Resident 5 required partial/moderate assistance (helper does less than half the effort) with toileting hygiene, lower body dressing, and putting on/taking off footwear. During a review of Resident 5's Order Summary Report, dated 11/21/2025, the Order Summary Report indicated a physician order with a start date of 9/15/2025 for: Fluid restriction: 1000 ml per 24 hours Dietary: 360 ml (breakfast=120 ml, lunch=120 ml, dinner= 120 ml) Nursing: 400 ml (7-3= 200 ml, 3-11= 100 ml, 11-7= 100 ml) and Nepro (a nutritional supplement) 1 tetra pack (240 ml) at 2 PM During a review of Resident 5's care plan, titled, Hemodialysis related to: End Stage Renal Disease, At risk for complications such as weight fluctuations, fluid loss, fluid gain, weight loss, dehydration. Resident 5's care plan interventions indicated to monitor intake and output (I&O) every shift. During an observation in the Dining Room on 11/20/2025, at 12:07 PM, Resident 5 was observed sitting in his walker in front of the table where a brown drink was being poured into red plastic cups by Restorative Nurse Assistant 1 (RNA 1). RNA 1 placed a tea bag and hot water in the red plastic cup and handed the red plastic cup to Resident 5. Resident 5 sat outside the dining room and drank his tea. Resident 5 handed the empty red plastic cup to RNA 1 who placed it on the table. Resident 5 left the Dining Room and went to his room. During a concurrent observation in Resident 5's room and interview on 11/20/2025, at 12:22 PM, with Resident 5, Resident 5 was observed sitting in his room eating a sandwich. Resident 5 had a brown paper bag and a small unopened 240 ml water bottle on top of his bedside table. Resident 5 also had 1 liter (l- unit of measurement for volume) water container next to his bed with approximately 100 ml of water inside. Resident 5 stated the sandwich and water bottle was from his sack lunch (a packed meal brought by Resident to dialysis) that he did not eat during dialysis. Resident 5 drank water from the water bottle and proceeded to pour the rest of the water into the 1liter water container. Resident 5 stated there was now 300 ml of water in his water container. Resident 5 stated he always poured the leftover water from his sack lunch into his water container because he did not like wasting water. Resident 5 stated he was only allowed to drink 1000 ml of water a day. Resident 5 stated facility staff does not ask him how much water he drinks from his water container every shift. During an observation in Resident 5's room, on 11/20/2025 at 12:26 PM, an unknown Certified Nursing Assistant (CNA) placed Resident 5's lunch tray on the resident's bedside table. Resident 5's lunch tray included a cup of water. Resident 5 drank half of the water in the cup but continued to eat his sandwich from his sack lunch. During an observation in Resident 5's room, on 11/20/2025, at 12:54 PM, an unknown CNA picked up Resident 5's lunch tray including the half cup of water and returned it in the lunch cart. Resident 5 only drank half of the water in the cup. During a concurrent interview and record review on, 11/20/2025, at 3:20 PM with Licensed Vocational Nurse 3 (LVN 3), Resident 5's Intake and Output Record form was reviewed. LVN 3 stated the Intake and Output Record form was used by licensed nurses to document Resident 5's fluid intake from medication administration and the resident's nutritional supplement. LVN 3 stated he did not know if CNAs documented Resident 5's I&O. During an interview, on 11/20/2025, at 3:26 PM with RNA 1, RNA 1 stated she gave Resident 5 tea in the dining room before lunch. RNA 1 stated she poured the tea in a 240 ml red		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555119	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/21/2025
NAME OF PROVIDER OR SUPPLIER Saint Vincent Healthcare		STREET ADDRESS, CITY, STATE, ZIP CODE 1810 N. Fair Oaks Ave Pasadena, CA 91103	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. (continued on next page)		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide pharmaceutical services to meet the needs of one of six sampled residents (Resident 47) in accordance with the facility's policy and procedure (P&P) by failing to: 1. Administer ferrous sulfate (a supplement used to treat or prevent iron deficiency, a condition that can lead to tiredness) every other day as ordered. 2. Administer Vitamin C (a supplement that the body needs to form collagen for skin, blood vessels, and bones, to heal wounds, and to protect cells from damage) daily as ordered. These deficient practices had the potential for Resident 47 to experience tiredness, shortness of breath, bruise or bleed easily, and poor wound healing. Findings: During a review of Resident 47's admission Record, the admission Record indicated Resident 47 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included anemia (condition where the blood does not carry enough oxygen to the rest of the body), moderate protein-calorie malnutrition (a nutritional deficiency characterized by symptoms like pale, dry, and easily bruised skin, hair changes, and joint pain), and dementia (a brain disorder that results in memory loss, poor judgment, and confusion). During a review of Resident 47's Minimum Data Set (MDS- a resident assessment tool), dated 9/1/2025, it indicated Resident 47 was assessed having severely impaired cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decision making. It indicated Resident 47 required supervision or touching assistance with eating, oral/personal hygiene, and upper body dressing. The MDS also indicated Resident 47 required partial/moderate assistance (helper does less than half the effort) with toileting hygiene, shower/bathe self, lower body dressing, sit to lying, rolling left and right, and walking 10 feet (ft- unit of measurement in distance). During a review of Resident 47's Order Summary Report, dated 11/21/2025, the Order Summary Report indicated a physician order for the following medications: 1. Ferrous Sulfate Oral Tablet, give 325 milligrams (mg- unit of measurement) by mouth one time a day every other day for anemia, with a start date of 1/21/2025. 2. Vitamin C tab (ascorbic acid), give 500 mg by mouth one time a day for supplement, with a start date of 4/3/2024. During an observation of Resident 47's medication administration (med pass) on 11/20/2025, at 9:24 AM, Licensed Vocational Nurse 2 (LVN 2) administered ferrous sulfate 325 mg 1 tablet by mouth to Resident 47. LVN 2 did not administer Vitamin C 500 mg to Resident 47. During an interview on 11/20/2025, at 4:49 PM, with LVN 2, LVN 2 stated Resident 47's ferrous sulfate was ordered to be administered every other day. LVN 2 stated Resident 47 last received ferrous sulfate was on 11/19/2025. LVN 2 stated she administered ferrous sulfate to Resident 47 on 11/20/2025. LVN 2 stated Resident 47 was not due to receive the resident's next dose of ferrous sulfate until 11/21/2025. LVN 2 stated it was important to administer ferrous sulfate as ordered to help increase the red blood cells in the resident's body. LVN 2 stated too much ferrous sulfate in the body can cause constipation (a condition where a person has infrequent bowel movements and/or finds it difficult to pass hard, dry stools) and black tarry stools (usually a sign of bleeding in the stomach or esophagus) During the same interview on 11/20/2025 at 4:49 PM, with LVN 2, LVN 2 stated Resident 47 was ordered to receive Vitamin C every day. LVN 2 stated she omitted and did not administer Resident 47's Vitamin C during med pass on 11/20/2025 as ordered. LVN 2 stated it was important for Resident 47 to get Vitamin C daily to increase and improve Resident 47's immune system. During an interview, on 11/21/2025, at 3:58 PM, with the Director of Nursing (DON), the DON stated ferrous sulfate worked concurrently with Vitamin C and should be administered as ordered by the physician. The DON stated the facility's P&P for administering medication as ordered by the physician was not followed. During a review of the facility's P&P, titled, Administering Medications, revised on 4/2019, the P&P indicated the following: 1. Medications are administered in a safe and timely manner, and as prescribed. 2. Medications are administered in accordance with prescriber orders, including any required time frame.		

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F 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Dispose of garbage and refuse properly. Based on observation, interview, and record review, the facility failed to maintain a debris-free dumpster area when trash was not properly contained, uncovered, and overflowing for two of five trash bins. This failure had the potential to result in pests (an organism that causes harm to humans such as flies, cockroaches, and rodents) entering the facility and spreading diseases to the residents. Findings: During a concurrent observation and interview on 11/18/2025 at 8:19 AM with the Kitchen [NAME] (KC) in the outdoor garbage area, there were two dumpsters, one grey trash bin, one black trash bin, and three green trash bins. The black trash bin was not completely closed. The grey trash bin beside the black trash bin did not have a lid and was overflowing with garbage. There were folded brown boxes and trash bags filled with personal protective equipment (PPE, clothing and equipment that is worn or used to provide protection against hazardous substances and/or environments) on the ground next to the grey trash bin. KC stated trash should not be left on the ground. KC stated ants, cockroaches, and flies can enter uncovered trash. KC stated pests can get inside the facility and spread disease to residents. During a concurrent observation and interview on 11/18/2025 at 8:30 AM with the Maintenance Supervisor (MS) in the outdoor garbage area, there was trash overflowing from two trash bins. MS stated trash bins should not be overfilled. MS stated garbage containers should be kept closed when not in use to prevent pests from getting inside. MS stated residents could get sick from diseases that pests spread. During a review of the facility's policy and procedure (P&P) titled, Food-Related Garbage and Refused Disposal, dated October 2017, the P&P indicated, outside garbage containers must have tight-fitting lids that remain closed when not in use and free of surrounding litter.		

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. (continued on next page)		

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure there was documented evidence of the hospice service (a program designed to provide a caring environment for meeting the physical and emotional needs of the terminally ill) visits and coordination in the resident's medical record for one (1) of 1 sampled resident (Resident 10) from the Hospice care area in accordance with the facility's policy and procedure) titled, Hospice Program. This deficient practice had the potential to result in a delay or lack of coordination in the delivery of hospice care and services to Resident 10. Findings: During a review of Resident 10's admission Record, the admission Record indicated the resident was admitted to the facility on [DATE] with diagnoses that included chronic obstructive pulmonary disease (COPD-a chronic lung disease causing difficulty in breathing) and dementia (a progressive state of decline in mental abilities). During a review of Resident 10's Minimum Data Set (MDS- a resident assessment tool), dated 10/9/2025, the MDS indicated Resident 10 had moderate impairment in cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decision making. The MDS also indicated Resident 10 was dependent (helper does all the effort) with shower and required substantial/maximal assistance (helper does more than half the effort) with toileting, lower body dressing and putting on/off footwear. The MDS further indicated Resident 10 required partial/moderate assistance (helper does less than half the effort) with oral and personal hygiene and upper body dressing and required supervision (helper provides cues) with eating. During a concurrent observation in Resident 10's room and interview on 11/19/2025 at 10:57 AM, Resident 10 was lying in bed and stated he was unsure whether Health Care Assistants/Nurses' Aide (HCA) came twice a week to visit the resident. Resident 10 also stated he would not know if they visited since they did not tell Resident 10 if they were from the hospice company. During a review Resident 10's plan of care dated 10/3/2025 with Registered Nurse Supervisor 2 (RNS 2), on 11/20/2025 at 10:05 AM, the plan for care update indicated certification period (a specific length of time for which a physician must certify that a resident is terminally ill with a prognosis of six months or less to live if the illness runs its normal course) from 10/3/2025 to 11/24/2025 and the ordered amount, frequency and duration of visits on the following discipline:1.) Skilled Nurse (SN) - 2x a week for 1 week, 2x a week for 9 weeks. Start October 2025. 2.) HCA - 2 x a week for 9 weeks. Start 10/5/2025 until 11/24/253.) Medical Social Worker (MSW) - 1 x per month x 3 months. Start 10/7/25 to 11/24/25. 4.) Clergy: 1x a month for 3 months. Start 10/7/25 to 11/24/25. During the concurrent interview and record review with Registered Nurse Supervisor 2 (RNS 2) on 11/20/2025 at 10:15 AM, Resident 10's hospice binder for the month of October and November 2025 was reviewed. RNS 2 stated the hospice binder had missed visits on the following discipline: 1.) SN - Registered Nurse (RN) was missing first (1st) and fourth (4th) week of October and missing 1st two (2) weeks of November. 2.) HCA - Missed 1 visit on the 1st week, third (3rd) week, and 4th week of October. HCA also Missed 1 visit on the second (2nd) week of November and none on the 3rd week of November.3.) Clergy - none for the month of October and November. RNS 2 stated the hospice staff were not following their scheduled visits, and the hospice binder did not have notes of the visits and what was provided for the month of November from SN, HCA, and MSW. RNS 2 also stated the charge nurse (lead nurse) in the morning shift should have coordinated with hospice staff to ensure they come on their scheduled visits and that Resident 10's needs were being met. RNS 2 further stated that licensed staff should ensure hospice notes are accessible and in the hospice binder to ensure the staff were updated and proper care was rendered to Resident 10. During an interview on 11/20/2025 11:24 AM, Licensed Vocational Nurse 1(LVN 1) stated the licensed staff including supervisors should have checked Resident 10's hospice binder's sign in log and ensure the hospice staff were logging in to verify they came on their scheduled visits. During an interview on 11/21/2025 at 8:45 AM, the Director of Nursing (DON) stated the hospice staff should be signing in whenever they come and visit Resident 10 to ensure that the delivery of care was provided to the resident. The facility staff (social workers and the licensed staff) should ensure hospice staff visits were based on the frequency indicated in Resident 10's plan of care dated 10/3/2025. During a review of the facility's Policy and Procedure (P&P) titled, Hospice Program, revised 7/2017, the P&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 residents needs. The P&P also indicated that the facility staff will coordinate care provided to the resident with the hospice staff		

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F 0911 Level of Harm - Potential for minimal harm Residents Affected - Some	Ensure resident rooms hold no more than 4 residents; for new construction after November 28, 2016, rooms hold no more than 2 residents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure two (2) of 27 rooms (rooms [ROOM NUMBERS]) accommodated no more than four (4) residents in each room. rooms [ROOM NUMBERS] have five (5) beds. This deficient practice has the potential for the residents' care and services not to be adequately accommodated, have an adverse effect on the residents' safety, and place residents at risk for lack of privacy. During the initial tour of the facility on 11/18/2025 from 9 AM to 9:15 AM, there were two rooms (13 and 14) observed with five beds in a room. The residents in rooms [ROOM NUMBERS] did not complain regarding the space in their room. There was enough space for the staff to provide care and enough storage for residents' belongings. One resident who was ambulatory and three (3) residents in room [ROOM NUMBER] who were wheelchair bound were able to move in the room without difficulty. Five (5) residents in room [ROOM NUMBER] who were wheelchair bound were able to move in the room without difficulty. Residents in room [ROOM NUMBER] and 14 were observed with ample spaces for residents to move about freely inside the rooms. Nursing staff had enough space to provide care for these residents, and there was space for the beds, side tables, dressers and resident care equipment. In room [ROOM NUMBER], four beds were occupied and one was vacant. In room [ROOM NUMBER], all five beds were occupied. A review of the facility's room waiver indicated the following: Room # of Beds Square Footage Sq Ft per Bed 13 5 357.19 71.44 14 5 356.25 71.25 During a review of the facility's room waiver letter, dated 11/18/2025, the facility's room waiver indicated a request for the continued waivers for rooms [ROOM NUMBERS] that have five beds in a room. It also indicated the rooms were in accordance with the special needs of the residents, and do not have an adverse effect on the residents' health and safety or impedes the ability of any resident in the rooms to attain his or her highest practicable well-being. The residents can be quickly and safely evacuated in the event of an emergency. The department would be recommending the room waiver for rooms [ROOM NUMBERS].		

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F 0912 Level of Harm - Potential for minimal harm Residents Affected - Some	Provide rooms that are at least 80 square feet per resident in multiple rooms and 100 square feet for single resident rooms. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to provide the minimum of 80 square feet (sq.ft. - unit of measurement) per resident bed in 25 of 27 resident rooms in the facility. This deficient practice had the potential to impact the ability to provide safe nursing care and privacy to the residents. During an observation of the residents' rooms one (1) to nine (9) and 11 to 26 on 10/18/2025 from 9 AM to 3:48 PM, 25 of 27 resident rooms did not meet the minimum 80 sq ft per resident in each room. The residents did not complain regarding the space in their room. There was enough space for the staff to provide care and enough storage for residents' belongings. All the Residents including the ones who were ambulatory and wheelchair bound were able to move in and out of the room without difficulty. During a concurrent observation in Resident 39's room (room [ROOM NUMBER]) and interview on 11/20/2025 at 1 PM, Resident 39 was observed resting in bed then walking to her closet then back to bed. Resident 39 stated she can move about the room without difficulty and that there is no furniture blocking her way. Resident 39 stated she has her own bed, table and closet inside the room and still has enough space. Resident 39 stated the nurses were able to help her without any problems. During an interview on 11/21/2025 at 2 PM with Certified Nurse Aide 3 (CNA 3), CNA 3 stated there was enough space in the residents' rooms to provide care to the residents. CNA 3 stated staff can move a recliner chair in and out of room [ROOM NUMBER] without issues. During a review of the Client Accommodations Analysis Form, Client Accommodations Analysis Form indicated the following: Room Beds Total Sq Ft Sq ft per Resident 1 3 213.75 71.252 2 145.55 72.783 3 213.09 71.034 2 146.11 73.055 3 213.09 71.036 3 213.89 71.307 3 213.89 71.30 8 3 213.10 71.039 3 213.10 71.0310 2 215.33 107.6711 3 213.10 71.0312 3 218.82 72.9413 5 357.19 71.4414 5 356.25 71.2515 3 213.10 71.0316 2 138.93 69.4717 3 216.28 72.0918 3 214.69 71.5619 2 145.56 72.7820 2 143.99 71.9921 3 213.10 71.0322 3 213.10 71.0323 3 215.63 71.8824 3 214.04 71.3425 3 212.63 70.8826 3 213.89 71.2927 2 219.29 109.65 During a review of the facility's Room Waiver request, dated 11/18/2025, the Room Waiver request indicated Rooms 1, 2, 3, 4, 5, 6, 7, 8, 9, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, and 26 measured less than the minimum requirement for room size. It also indicated that Resident rooms [ROOM NUMBERS] are in compliance with the minimum 80 sq ft per resident. The Request Waiver indicated a request for the continued waiver for square footage per resident. Room Beds Total Sq Ft 1 3 213.75 2 2 145.55 3 3 213.09 4 2 146.11 5 3 213.09 6 3 213.89 7 3 213.89 8 3 213.10 9 3 213.10 10 2 215.33 11 3 213.10 12 3 218.82 13 5 357.19 14 5 356.25 15 3 213.10 16 2 138.93 17 3 216.28 18 3 214.69 19 2 145.56 20 2 143.99 21 3 213.10 22 3 213.10 23 3 215.63 24 3 214.04 25 3 212.63 26 3 213.89 27 2 219.29 During this re-certification survey from 11/18/2025 to 11/21/2025, the above listed rooms had sufficient space for the residents' freedom of movement. The rooms had adequate space to provide nursing care, privacy during care, and the ability to maneuver resident care equipment in the rooms. The room size did not present any adverse effect on the residents' personal space, nursing care, and comfort. The Department would be recommending the room waiver for Rooms 1, 2, 3, 4, 5, 6, 7, 8, 9, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, and 26.		