

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055862	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/12/2024
NAME OF PROVIDER OR SUPPLIER Golden Rose Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1899 N Raymond Ave Pasadena, CA 91103	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide appropriate pressure ulcer care and prevent new ulcers from developing.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45099</p> <p>Based on observation, interview, and record review the facility failed to provide services to promote healing of pressure ulcers (damage to an area of the skin caused by constant pressure on the area for a long time) and deep tissue injury (DTI, purple or maroon localized area of discolored intact skin or blood-filled painful swelling on the surface of the skin due to damage of underlying soft tissue from pressure) for two (2) of three (3) sampled residents (Resident 1 and 2) in accordance with the facility ' s policy when:</p> <ol style="list-style-type: none"> 1. Resident 1, facility did not implement a consistent wound care treatment as ordered by physician and develop a care plan for care and management of resident 1 ' s pressure ulcers and DTI. 2. Resident 2, facility did not set low air loss mattress (LAL, mattress used for residents who are at risk for developing sores or already have pressure ulcer designed to circulate a constant flow of air for the management of pressure sores) correctly according to Resident 2's weight and did not implemented turning and repositioning every two hours (q2hr) to prevent and facilitate healing of pressure ulcer. <p>These deficient practices placed Resident 1 and 2 at risk for development of new pressure ulcer and progression of current pressure ulcers.</p> <p>Findings:</p> <ol style="list-style-type: none"> 1. During a review of Resident 1's Admission Record, the Admission Record indicated the resident was admitted to the facility on [DATE] with diagnoses that included dysphagia (difficulty swallowing), quadriplegia (paralysis from the neck down, including legs, and arms, usually due to a spinal cord injury), and traumatic brain injury (TBI-a disruption in the normal function of the brain that can be caused by a bump, blow, or jolt to the head). <p>During a review of Resident 1's Minimum Data Set (MDS- a federally mandated assessment tool), dated 10/20/2024, the MDS indicated Resident 1 had severely impaired cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decision making. The MDS also indicated Resident 1 was dependent (helper does all the effort) with eating, oral, personal and toileting hygiene, shower, upper and lower body dressing, and putting on/taking off footwear. The MDS further indicated Resident 1 had one (1) unhealed pressure ulcer, 1 unstageable pressure ulcer present upon admission, and 2 unstageable DTI ' s.</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 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a review of Resident 1 ' s Care Plan, the Care Plan did not indicate care and management for Resident 1 ' s unstageable pressure ulcer on the Sacro coccyx area, and DTIs on the left heel, left dorsalis pedis (on top of the foot), and left malleolus (bony protrusion on the side of the ankle).</p> <p>During a review of Resident 1 ' s physicians order dated 10/13/2024, the physician ' s order indicated the following:</p> <p>a) Unstageable pressure ulcer (a wound with an undetermined level of tissue injury because the entire base of the wound is covered by dead tissue separating from living tissue and/or dead tissue that falls off from healthy skin) on Sacro-coccyx (pertains to both large triangular shaped bone in the lower spine that forms part of the pelvis and the tailbone) area - cleanse with dakins solution (a fraction of antiseptic solution containing sodium hypochlorite that was developed to treat infected wounds) 0.125 %, pat dry, apply Santyl ointment (a medicine that removes dead tissue from the wounds so they can start to heal) then cover with bordered dressing as needed for dislodgement/soilage and every day shift.</p> <p>b) Left heel DTI - cleanse with Normal Saline (NS, a saltwater solution) pat dry, paint with betadine solution (a chemical agent that prevents or slows the growth of microorganisms on the body ' s external surfaces) then cover with bordered dressing daily on day shift.</p> <p>c) Left Malleolus DTI - cleanse with NS, pat dry, paint with betadine solution then covered with bordered dressing daily on day shift.</p> <p>d) Left dorsalis pedis DTI - cleanse with NS, pat dry, paint with betadine solution then covered with bordered dressing daily on day shift for 14 days and re-assess.</p> <p>During a review of Resident 1 ' s Treatment Administration Record (TAR) for the month of October 2024, the TAR had missing wound care treatments on 11/14/2024, 11/15/2024, 11/18/2024, and 11/19/2024 for the following:</p> <p>a) Unstageable pressure ulcer on the Sacro coccyx</p> <p>b) Left heel DTI</p> <p>c) Left malleolus DTI</p> <p>d) Left dorsalis pedis DTI</p> <p>During an interview on 12/12/2024 at 5:11 PM, Registered Nurse 1 (RN 1) stated, the Treatment Nurse (TN) should sign the TAR if they provided the wound care treatment. RN 1 also stated if the TAR is not signed it is not done.</p> <p>A review of the facility's policy and procedure titled, Documentation - Nursing, revised June 1, 2017, indicated its purpose was to provide documentation of resident ' s status and care given by nursing staff. The policy also indicated that medication administration and treatment administration records are completed with each medication or treatment completed. The policy further indicated that treatments are to be completed and documented as per physician ' s order and will be completed by the end of the assigned shift.</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 12/12/2024 at 1:44 PM, RN 1 confirmed Resident 2 RN was not turned to his side. RN 1 also stated Resident 2 ' s pressure ulcer could get worse if the resident was not getting turned every 2 hours.</p> <p>During an interview on 12/12/2024 at 2:39 PM, Certified Nursing Assistant 1 (CNA 1) stated Resident 2 was turned at 1:25 PM using only a pillow but could not keep the resident turned. Stated Resident 2 would need a turn wedge (a body positioning aid that allows users to comfortably position at precisely the desired angle) to keep him on his side. CNA 1 also stated if Resident 2 is not turned correctly, the resident could develop more pressure ulcers.</p> <p>During an interview on 12/12/2024 at 4:25 PM, the Director of Nursing (DON) Resident 2 ' s LAL was not at the correct setting. The DON also stated the staff defeated the purpose of the LAL mattress because it was supposed to prevent further skin breakdown and help with the healing process. The DON further stated Resident 2 should be properly turned to prevent pressure ulcer from getting worse and prevent new ulcer from developing.</p> <p>A review of the facility's policy and procedure titled, Pressure Ulcer Prevention, revised June 1, 2017, indicated its purpose was to identify residents at risk for skin breakdown, implement measures to prevent and/or manage pressure ulcers and minimize complications. The policy also indicated that the licensed nurse would develop a care plan specific to the resident ' s risk factors.</p> <p>A review of the facility's Med-Aire 8-inch Alternating Pressure Mattress Replacement System with LAL manufacturers manual, the manufacturers manual on pressure range selection indicated users can adjust the pressure level of the air mattress using the analog pressure dial, to a desired firmness based on personal comfort or weight setting.</p>		