STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055862	A. Building B. Wing	12/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Golden Rose Care Center	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)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. 46087 Based on interview and record review, the facility failed to provide ensure a neurological assessment (neuro check, a group of questions and tests to check for disorders of the nervous system [sends messages back and forth between the brain and the body]) was completed for one (1) of two (2) sampled residents (Resident 1) who had an unwitnessed fall, in accordance with the facility's policy and procedure (P&P) titled, Neurological Assessment,. This deficient practice had the potential to result in a delay of care and services, which could negatively affect Residents 1's overall wellbeing. Findings: During a review of Resident 1's Admission Record indicated the facility admitted Resident 1 on 9/6/2024. Resident 1's diagnoses included history of falling, anxiety (persistent and excessive worry that interferes with daily activities), and muscle wasting (weakening, shrinking, and loss of muscle). During a review of Resident 1's Minimum Data Set (MDS - a resident assessment tool) dated 9/14/2024, indicated Resident 1 was severely impaired with cognitive (processes of thinking and reasoning) skills for daily decision making. The MDS indicated Resident 1 required partial/moderate assistance (helper does less than half the effort) with eating. The MDS indicated Resident 1 required substantial/ maximal assistance (helper does more than half the effort) with oral hygiene, upper body dressing and personal hygiene. The MDS also indicated Resident 1 was dependent (helper does all the effort) with toileting hygiene, shower / bathe self, lower body dressing and putting on/taking off footwear. During a review of Resident 1's Change in Condition (COC) Evaluation, dated 12/22/2024 timed at 1:50 PM, indicated Resident 1 was found sitting on the floor next to her bed. The COC evaluation indicated 72 hours neuro check was a recommendation of primary clinician. During a review of Resident 1's Care Plan regarding Resident 1 had an unwitnessed fall related to balance problems, initiated 12/22/2024, indicated the following interventions: Monitor/document/report as needed for 72 hours to Medical Doctor (MD) for signs and symptoms of pain, bruises, change in mental status. Neuro-check per policy and procedure. (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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 1's Neurological assessment flowsheet (tool used to assess, monitor, and record specific neurological signs/status following an injury resulting in suspected or actual head trauma), initiated on 12/22/2024 at 1:50 PM, instructions indicated to document the date and time of each assessment. The flowsheet indicated the following assessments: Level of consciousness Pupil response (the change in pupil [the black hole seen at the center of the eye) size in response to light. It reflects the brain activity or response and possibly detect brain problems) Motor functions Pain response Vital signs (measurements of the body's most basic functions) Observations Signature (of the person completing the form) The flowsheet indicated the following neuro check schedule: Every 15 minutes, times four (4) Every 30 minutes, times 2 Every 1 hour, times 2 Every 2 hours, times 2 Every 4 hours, times 4 Every eight (8) hours, times 6 The flowsheet indicated the last neuro check documented was on 12/22/2024 at 3:05 PM. The flowsheet indicated the following dates and time were left blank: 12/22/2024 at 3:35 PM (1 hour and 45 minutes from the time of unwitnessed fall and 30 minutes from the last neuro check documented) 12/22/2024 at 4:35 PM 12/22/2024 at 5:35 PM 12/22/2024 at 7:35 PM 12/22/2024 at 9:35 PM (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	12/23/2024 at 5:35 AM 12/23/2024 at 9:35 AM 12/23/2024 at 1:35 PM 12/24/2024 at 5:35 AM 12/24/2024 at 1:35 PM During a concurrent interview and record review on 12/20/2024 at 1:25 PM with Quality Assurance Nurse (QAN), Resident 1's Neurological assessment flowsheet, initiated on 12/22/2024 was reviewed. QAN verified the flowsheet for Resident 1 has incomplete documentation. QAN stated the following dates and time has no documentation/ left blank: 12/22/2024 at 3:35 PM 12/22/2024 at 4:35 PM 12/22/2024 at 5:35 PM 12/22/2024 at 7:35 PM 12/22/2024 at 9:35 PM 12/23/2024 at 5:35 AM 12/23/2024 at 9:35 AM 12/23/2024 at 1:35 PM 12/24/2024 at 5:35 AM 12/24/2024 at 1:35 PM (total of 10 missed assessments) QAN added it is important to follow the Neurological assessment flowsheet and the frequency of assessment to ensure resident's safety. QAN also stated, if form is not followed, it places resident at risk for developing complications due to the unwitnessed fall and delay in care and/or treatment. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review on 12/24/2024 at 2:20 PM with Licensed Vocational Nurse 1 (LVN 1), Resident 1's Neurological assessment flowsheet, initiated on 12/22/2024 was reviewed. LVN 1 stated he is aware that Resident 1 had an unwitnessed fall on 12/22/2024. LVN 1 stated Neurological assessment flowsheet for Resident 1 was not endorsed to him this morning by the outgoing LVN. LVN 1 stated he did not do neuro check to Resident 1 when he started his shift today (12/24/2024 at 7 AM). LVN 1 verified Resident 1's neurological assessment flowsheet indicated multiple dates and time, with total of 10 with missing assessment. LVN 1 stated Resident 1 is scheduled to have a neuro check at 1:35 PM, but LVN 1 did not do it. LVN 1 stated it is important to check and follow time indicated in the neurological assessment flow sheet to check if there is change of condition or complications from the unwitnessed fall and to ensure the facility provides timely care and treatment to Reisdent 1. During an interview on 12/24/2024 at 2:52 PM with Registered Nurse (RN 1), RN 1 stated she was in the facility when Resident 1 had an unwitnessed fall incident on 12/22/2024. RN 1 stated neuro check assessment can be done by Resident 1's assigned licensed nurse or registered nurse. RN 1 stated neurological assessment flowsheet indicated the scheduled times of assessment and licensed nurses must follow it. RN 1 stated it is their practice and policy to do 72 hours neuro check to residents after the resident's unwitnessed fall. During an interview on 12/24/2024 at 3:05 PM with RN 2, RN 2 stated when conducting neuro check, Pupils Equal, Round, Reactive to Light and Accommodation (PERRLA, pupillary response test), vital signs, extremities, and resident responsiveness are assessed. RN 2 stated a neuro check is performed if there were no witnesses following a resident's fall. RN 2 stated when a neuro check was refused, interventions include to call for another nurse to conduct the neuro check assessment, and if the resident still refused, the physician (MD) was notified. RN 2 stated refusals must be documented. RN 2 verified Resident 1 has no documentation of neuro check refusal. RN 2 stated a neuro check must be done to monitor any head injury, bleeding, or swelling to the brain or the change in a resident's level of consciousness. RN 2 stated residents could 'pass out' and lose consciousness after an unwitnessed fall because of a potential head/ brain injury. RN 2 added neuro check assessment was important to detect early change in condition and level of consciousness in the resident. During a review of facility's P&P titled, Neurological Assessment, revised 6/1/2017, indicated the purpose of this procedure is to provide guidelines for neurological assessment: 1) Upon physician order 2) Following an unwitnessed fall 3) Following a fall or other accident/injury involving head trauma 4) When indicated by resident's condition The P&P also indicated the neurological checks will be performed as follows or otherwise ordered by the Physician: a. Every 15 minutes for 1 hour, then; b. Every 30 minutes for 1 hour, then; (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	c. Every hour for 2 hours, then; d. Every 4 hours for a combined total of 72 hours. It also indicated the following information will be documented in the resident's medical record: The date and time the procedure was performed. The name and title of the individual who performed the procedure. All assessment data obtained during the procedure, including eye opening, verbal response, motor response, pupillary response, and limb response. If the resident refused the procedure, the reason(s) why and the intervention taken. The signature and title of the person recording the data.

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F 0756

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures.

46087

Based on interview and record review, the facility failed to note, document and report to the resident's primary physician the irregularities (includes, but is not limited to, use of medications without adequate indication, without adequate monitoring, in excessive doses, and/or in the presence of adverse consequences, as well as the identification of conditions that may warrant initiation of medication therapy) with regards to the Lorazepam order, on the medication regimen review (MRR, or Drug Regimen Review, a thorough evaluation of the medication regimen of a resident, with the goal of promoting positive outcomes and minimizing adverse consequences and potential risks associated with medication) done on 11/29/2024 to 11/30/2024 for one of two sampled Residents (Resident 1) in accordance with the facility policy titled Psychotherapeutic (the practice of prescribing, monitoring, and adjusting medications used to treat mental health conditions) Drug Management,.

This deficient practice had the potential for unnecessary medication administration to Resident 1, which could result to serious harm.

Corss reference with 758.

Findings:

During a review of Resident 1's Admission Record indicated the facility admitted Resident 1 on 9/6/2024. Resident 1's diagnoses included history of falling, anxiety (persistent and excessive worry that interferes with daily activities), and muscle wasting (weakening, shrinking, and loss of muscle).

During a review of Resident 1's Minimum Data Set (MDS - a resident assessment tool) dated 9/14/2024, indicated Resident 1 was severely impaired with cognitive (processes of thinking and reasoning) skills for daily decision making. The MDS indicated Resident 1 required partial/moderate assistance (helper does less than half the effort) with eating. The MDS indicated Resident 1 required substantial/ maximal assistance (helper does more than half the effort) with oral hygiene, upper body dressing and personal hygiene. The MDS also indicated Resident 1 was dependent (helper does all the effort) with toileting hygiene, shower / bathe self, lower body dressing and putting on/taking off footwear.

During a review of Resident 1's Order Summary Report dated 12/24/2024, indicated the following orders:

o Lorazepam oral tablet 0.5 milligrams (mg, unit of measurement), 1 tablet by mouth every eight (8) hours as needed (PRN) for restlessness, with order date of 11/28/2024.

o Lorazepam oral tablet 0.5 mg, 1 tablet by mouth every six (6) hours as needed for restlessness, with order date of 12/23/2024.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 12/24/2024 at 1:55 PM with Registered Nurse 2 (RN 2), Resident 1's physician order summary dated 12/24/2024 was reviewed. RN 2 stated Resident 1's Lorazepam order on 11/28/2024 and 12/23/2024 were incomplete because it did not have a diagnosis and specific target behavior. RN 2 stated Resident 1 did not have and should have an order for monitoring of specific target behavior for the use of Lorazepam and an order to monitor adverse reaction for the use of Lorazepam. RN 2 stated this was necessary, so the staff know what the medication is for and specific behavior/ manifestation to monitor so the facility would know if the behavioral management was effective or not. During a concurrent telephone interview and record review on 12/24/2024 at 2:27 PM with Pharmacy Consultant (PC), Consultant Pharmacist's Medication Regimen Review dated 11/29/2024 and 11/30/2024 were reviewed. PC stated Lorazepam is usually ordered for diagnosis of anxiety and to manage behaviors. PC stated Resident 1's Lorazepam order of 0.5 mg tablet as needed for restlessness since 11/28/2024 should have been reviewed for clarification of order wherein Resident 1's diagnosis such as anxiety and manifested by specific type of behavior such as getting up from bed without assistance and fidgeting (small movements especially of hands and feet when a person is nervous) Resident 1 is presenting should have been indicated in the Lorazepam order. PC stated she missed Resident 1's Lorazepam order that is why there was no report to the attending physician and no recommendation for the Lorazepam to indicate diagnosis, specific behavior, to order monitoring or specific behavior for Lorazepam use and to order monitoring of adverse reaction to anti-anxiety medication on the MRR report for Resident 1 since November 2024. During a concurrent interview and record review on 12/24/2024 at 3:35 PM with Quality Assurance Nurse (QAN), Resident 1's medical records was reviewed. QAN stated Resident 1's monthly MRR created between 11/29/2024 and 11/30/2024 did not indicate any recommendation (clarifying order with prescribing Doctor, to indicate diagnosis and specific target behavior for the ordered medication) from PC for Resident 1's Lorazepam order. QAN stated if the PC had documented the irregularity and recommendation to add Resident 1's diagnosis, specific target behavior, monitoring of specific target behavior and to monitor adverse reaction for Lorazepam use, then it could have been discussed with Resident 1's Psychiatrist (medical doctor who specializes in mental health). QAN added monitoring of adverse reaction to Lorazepam use is important to know if medication is suitable for the resident, and adverse reactions can potentially harm the resident that can lead to hospitalization . During a review of facility's P&P, titled Psychotherapeutic (the practice of prescribing, monitoring, and adjusting medications used to treat mental health conditions) Drug Management, revised on 10/24/2022, P&P indicated Pharmacist (a person who is professionally qualified to prepare and dispense medicinal drugs) responsibility as follows: The consulting Pharmacist will review the monthly psychotherapeutic summary and make recommendations as appropriate. The consulting Pharmacist will note in the resident's medical record that the pharmacy medication review regimen was completed. The consulting Pharmacist will report any irregularities such as unnecessary drugs (which include but are not limited to excessive

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. 46087 Based on observation, interview, and record review, the facility failed to ensure one (1) of two (2) sampled residents (Resident 1) was free from an unnecessary psychotropic drug (any medication capable of affecting the mind, emotions, and behavior) in accordance with the facility policy and procedure (P&P) titled Psychotherapeutic Drug Management, by failing to ensure: A. Resident 1 have a specific indication for a specific diagnosis in the physician's order for the use of Lorazepam (medication used to treat anxiety [persistent and excessive worry that interferes with daily activities]). B. Resident 1 have indication for a specific target behavior such as trying to get up of bed without assistance and fidgeting (small movements especially of hands and feet when a person is nervous) indicated in the physician's order for the use of Lorazepam. C. Resident 1's Lorazepam as needed order was discontinued after 14 days from the order start date. D. Resident 1 have an order to monitor/document/report any adverse (harmful) reactions to anti-anxiety therapy. E. Resident 1 have an order to monitor/record occurrence of target behavior for the use of Lorazepam. These deficient practices had the potential to place Resident 1 at risk for significant adverse consequences from the use of unnecessary psychotropic drug, which could result to impairment or decline in the residents' mental, physical condition, functional, and psychosocial status. Findings: During a review of Resident 1's Admission Record indicated the facility admitted Resident 1 on 9/6/2024. Resident 1's diagnoses included history of falling, anxiety, and muscle wasting (weakening, shrinking, and loss of muscle). During a review of Resident 1's Minimum Data Set (MDS - a resident assessment tool) dated 9/14/2024, indicated Resident 1 was severely impaired with cognitive (processes of thinking and reasoning) skills for daily decision making. The MDS indicated Resident 1 required partial/moderate assistance (helper does less than half the effort) with eating. The MDS indicated Resident 1 required substantial/ maximal assistance (helper does more than half the effort) with oral hygiene, upper body dressing and personal hygiene. The MDS also indicated Resident 1 was dependent (helper does all the effort) with toileting hygiene, shower / bathe self, lower body dressing and putting on/taking off footwear. During a review of Resident 1's Order Summary Report dated 12/24/2024, indicated the following orders: (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Lorazepam oral tablet 0.5 milligrams (mg, unit of measurement), 1 tablet by mouth every eight (8) hours as needed (PRN) for restlessness, with order date of 11/28/2024. Lorazepam oral tablet 0.5 mg, 1 tablet by mouth every six (6) hours as needed for restlessness, with order date of 12/23/2024. During a review of Resident 1's care plan regarding Resident 1's anti-anxiety medications related to restlessness, revised on 11/7/2024, it indicated the following interventions: Administer anti-anxiety medications as ordered by physician. Monitor for side effects and effectiveness every shift. Monitor/document/report as needed adverse reactions to anti-anxiety therapy: Drowsiness, lack of energy, clumsiness, slow reflexes, slurred speech, confusion and disorientation, depression, dizziness, lightheadedness, impaired thinking and judgment, memory loss, forgetfulness, nausea, stomach upset, blurred or double vision. Monitor/record occurrence of target behavior symptoms (restlessness) and document per facility protocol. During a concurrent interview and record review on 12/24/2024 at 1:25 PM with Quality Assurance Nurse (QAN), Resident 1's medication administration record for the month of December 2024 was reviewed. QAN verified Resident 1 received Lorazepam 0.5 mg on 12/1/2024, 12/5/2024, 12/9/2024, 12/13/2024, 12/14/2024, 12/16/2024, 12/17/2024, 12/19/2024, 12/20/2024, 12/21/2024. QAN stated the Lorazepam order was incomplete because it did not have a diagnosis and specific target behavior such as resident getting up from bed without assistance and fidgeting. QAN stated the Lorazepam order should indicate for which diagnosis it was indicated for the resident which is for the resident's anxiety. QAN added PRN Lorazepam ordered on 11/28/2024 should have been discontinued after 14 days from order date. QAN was unable to provide a written documentation from Resident 1's Physician's regarding extending the PRN Lorazepam order beyond 14 days. QAN stated Resident 1 anxiety is usually manifested by episodes of restlessness and trying to get up from bed without assistance and it should be indicated in the Lorazepam order the specific behavior (restlessness and trying to get up from bed without assistance) the Lorazepam was supposed to be given for. QAN stated it was important to have a complete physician order before administering medication to ensure the resident receives the correct medication for the correct indication. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 12/24/2024 at 1:50 PM with Registered Nurse 2 (RN 2), Resident 1's physician order dated 12/24/2024 was reviewed. RN 2 stated Resident 1's Lorazepam order dated on 11/28/2024 and 12/23/2024 did not and should have a specific behavior to be monitored for its use. RN 2 stated it was important to include the specific target behavior so the licensed nurses would know when to administer Lorazepam. RN 2 stated specific behavior manifestation for anxiety such as fidgeting (the act of moving about restlessly in a way that is not essential to ongoing tasks or events) and attempting to get up without assistance, should have been included in the physician's order for the Lorazepam to ensure the PRN medication is given as indicated to prevent adverse reactions. RN 2 stated Resident 1 did not have and should have an order to monitor adverse reaction to anti-anxiety medication (Lorazepam). RN 2 stated that antianxiety medication needs monitoring of specific target behavior so the facility would know if the medication was effective to manage the behavior or not. RN 2 stated specific behavior manifestation such as screaming, resident's verbalization of having anxiety, breathing fast should have been in the order, and an order of behavior monitoring that to be tallied by hashmark should be active to have validation for the effectiveness or the need of medication adjustment. During a review of facility's P&P, titled Psychotherapeutic Drug Management, revised on 10/24/2022, its purpose is to ensure the resident receives only those medications, in doses and for the duration clinically indicated to treat the resident's assessed condition(s). The procedure indicated the psychotherapeutic medication order will include the following information: Diagnosis for the medication. Indications and manifestations of the disorder treated. The procedure also indicated residents should not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record. PRN orders for psychotropic drugs are limited to 14 days. If the Attending Physician believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order.