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	03/11/2025

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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45099 Based on interview and record review, the facility failed to ensure a current copy of the advance directives (a legal document indicating resident preference on end-of-life treatment decisions) were placed in the resident's chart with the Physician Orders for Life-Sustaining Treatment (POLST, a portable medical order form that records patients' treatment wishes so that emergency personnel know what treatments the resident wants in the event of a medical emergency, taking the patient's current medical condition into consideration) and failed implement the resident's advance directives for one (1) of two (2) sampled residents (Resident 1). This deficient practice resulted to conflict in carrying out Resident 1's wishes for medical treatment and resident's health care decisions when the resident went into respiratory arrest (a person has completely stopped breathing) with no pulse being detected on [DATE] and CPR was provided by facility staff. Findings: During a review of Resident 1's Admission Record, the Admission Record indicated the resident was admitted to the facility on [DATE] with diagnoses of acute embolism and thrombosis of right internal jugular vein (a sudden, serious blood clot has formed in the major vein in the neck where a piece of that clot could potentially travel to other parts of the body) and paroxysmal atrial fibrillation (a type of irregular heartbeat where the hearts upper chambers beat irregularly and rapidly). During a review of Resident 1's Minimum Data Set (MDS- a resident assessment tool), dated [DATE], the MDS indicated Resident 1 had an intact 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) on lower body dressing and putting on/taking off footwear and required substantial/ maximal assistance (helper does more than half the effort) with shower and upper body dressing. The MDS further indicated Resident 1 required partial/moderate assistance (helper does less than half the effort) with oral, and toileting hygiene and required supervision (helper provides cues) with eating. During a review of Resident 1's nurses' progress notes dated [DATE], the nurses progress notes indicated LVN 1 called 911 (a universal emergency number) at 12:32 AM and CPR, began at 12:42 AM when Resident 1 went into respiratory arrest with no pulse being detected. (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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on [DATE] at 10:06 AM, FAM 1 stated the facility did not follow the instructions in the Advanced Directive. FAM 1 also stated she provided the facility with a notarized copy of Resident 1's Advance Directive (unable to recall when) which indicated do not resuscitate [DNR, a medical order written by a doctor to instruct healthcare providers NOT to do cardiopulmonary resuscitation {CPR- a lifesaving technique used when someone's heart stops beating, or they stopped breathing}] Resident 1 if breathing stops or the heart stops beating. During a concurrent interview and record review on [DATE] at 10:40 AM, Resident 1's medical records dated from [DATE] to [DATE] were reviewed. There were no Advance Directives attached or included in Resident 1's medical records. The Social Services Director (SSD) confirmed Resident 1's Advanced Directive was not in the resident's chart. The SSD stated the Advanced Directive should be in Resident 1's medical records/ chart as part of Resident 1's decision making for life sustaining treatment during emergencies. The SSD further stated the Advanced Directive should also be in the residents' chart so the staff would know who the responsible person and decision maker for the resident. During a concurrent interview and record review on [DATE] at 10:55 AM, the Director of Nursing (DON) stated Advanced Directives should be in the chart so the facility would be aware of the resident/responsible party's wishes in case of emergencies. The DON also stated during emergencies the facility should follow the residents Advanced Directive and Resident 1's wishes was not followed to not provide CPR to the resident when the resident stopped breathing and did not have a pulse since the Advanced Directive was not in the resident's chart prior to providing CPR on [DATE]. During a concurrent interview and record review on [DATE] at 12:02 PM with the DON, Resident 1's Advanced Directive dated [DATE] was reviewed. The Advanced Directive indicated it was signed by Resident 1 on [DATE] and indicated the resident's choice not to prolong his life (No CPR) under End-of-Life Decision (directions to the health care providers and others involved in your care to provide, withhold, or withdraw treatment in accordance with your choice). The DON stated the facility was able to find Resident 1's advance directive after the surveyor exited the facility on [DATE] mixed with Resident 1's General Acute Care Hospital Records and it should have been placed with Resident 1's POLST when the resident was admitted at the facility. During a review of the facility's policy and procedure titled, Advanced Directives, revised [DATE], indicated its purpose was to provide residents the opportunity to make decisions regarding their health care. The policy also indicated that a copy of the Advanced Directive is maintained as part of the resident's medical record.

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45099 Based on interview and record review, the facility failed to ensure resident's Physician Orders for Life-Sustaining Treatment (POLST, a portable medical order form that records patients' treatment wishes so that emergency personnel know what treatments the resident wants in the event of a medical emergency, taking the patient's current medical condition into consideration) that confirmed the residents/resident's representatives wishes for do not resuscitate [DNR, a medical order written by a doctor to instruct healthcare providers NOT to do cardiopulmonary resuscitation {CPR- a lifesaving technique used when someone's heart stops beating, or they stopped breathing}] if breathing stops or the heart stops beating) for 1 of 2 sampled residents (Resident 1) was complete with the doctor's signature This deficient practice resulted in conflict in carrying out Resident 1's wishes for medical treatment and health care decisions when the resident went into respiratory arrest (a person has completely stopped breathing) with no pulse being detected on [DATE] and CPR was provided by facility staff. Findings: During a review of Resident 1's Admission Record, the Admission Record indicated the resident was admitted to the facility on [DATE] with diagnoses of acute embolism (occurs when a substance that travels through the blood stream lodges in a blood vessel, obstructing blood flow) thrombosis of right internal jugular vein (a sudden, serious blood clot has formed in the major vein in the neck where a piece of that clot could potentially travel to other parts of the body) and paroxysmal atrial fibrillation (a type of irregular heartbeat where the hearts upper chambers beat irregularly and rapidly). During a review of Resident 1's Minimum Data Set (MDS- a resident assessment tool), dated [DATE], the MDS indicated Resident 1 had an intact 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) on lower body dressing and putting on/taking off footwear and required substantial/ maximal assistance (helper does more than half the effort) with shower and upper body dressing. The MDS further indicated Resident 1 required partial/moderate assistance (helper does less than half the effort) with oral, and toileting hygiene and required supervision (helper provides cues) with eating. During a review of Resident 1's nurses' progress notes dated [DATE], the nurses progress notes indicated LVN 1 called 911 (a universal emergency number) at 12:32 AM and CPR, began at 12:42 AM when Resident 1 went into respiratory arrest with no pulse being detected. During an interview on [DATE] at 7:15 AM, Licensed Vocational Nurse 1 (LVN 1) stated it should be licensed nurses and/ or Social Services Director (SSD) responsibility to ensure the POLST is completed including a signature from the physician. During a concurrent interview and record review with the Director of Nursing (DON), on [DATE] at 10:55 AM, Resident 1's POLST dated [DATE] was reviewed. The POLST indicated the following: (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	a) Section A - DNR b) Section B - Comfort focused treatment (prioritizing a person's comfort and well-being, during illness or end-of life, by managing symptoms and providing support, rather than focusing solely on curing the illness). c) Section C - No artificial means of nutrition, including feeding tubes (a tube inserted into the stomach to provide nutrition when a person is unable to eat adequately through their mouth). d) Section D - Advanced Directive dated [DATE] was available and reviewed with the health care agent signed by FAM 1 who was the legally recognized decisionmaker. The POLST was left blank under physician's signature. The DON stated Advanced Directives should be in Resident 1's chart so the facility would be aware of the resident/responsible party's wishes in case of emergencies. The DON also stated during emergencies the facility should follow the residents Advanced Directive/ POLST. The DON further stated the physician had to sign the POLST to confirm the DNR status of the resident. During an interview on [DATE] at 12:38 PM, Resident 1's Medical Doctor (MD/Physician) stated he was unaware and did not recall anyone telling him Resident 1 was a DNR. The Physician also stated POLST should be signed by the physician because it becomes a legal document that nurses could follow in case residents goes into cardiac arrest (when the heart suddenly stops beating). During a review of the facility's policy and procedure titled, Physician Orders for Life Sustaining Treatment (POLST), revised [DATE], indicated its purpose was to ensure that the facility honors residents' treatment wishes concerning resuscitation and life-sustaining treatment. The policy also indicated that the POLST must be signed by a physician or a nurse practitioner or a physician assistant acting under the supervision of the physician and within the scope of practice authorized by law, to be legally effective. During a review of the facility's policy and procedure titled, Completion and Correction, revised [DATE], indicated its purpose was to ensure that medical records are complete and accurate. The policy also indicated that the facility would work to complete and correct medical records in a standardized manner to provide highest quality and accuracy in documentation.