

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 03/13/2025
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 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48395</p> <p>Based on observation, interview and record review, the facility failed to provide supervision and a safe environment to prevent accidents for three (3) of 3 sampled residents (Residents 1, 2 and 3) by failing to:</p> <ol style="list-style-type: none"> 1. Ensure Resident 1 did not obtain and consume alcohol on facility grounds on 3/9/2025. 2. Ensure Residents 1, 2 and 3 were supervised while spending time outside by the parking lot and in the smoking area to either smoke or relax on 3/9/2025 and 3/12/2025. 3. Implement their facility's policy and procedure (P&P) titled, Smoking regarding non-compliance and Resident 1's interdisciplinary team meeting (IDT; a group of professionals from different disciplines who collaborate to achieve a common goal, often focusing on a patient's needs or a complex problem) interventions on 10/8/2024 to have an IDT meeting every Friday regarding Resident 1's smoking related violations and on 1/20/2025 that smoking materials will be continued to be kept in a secure place by facility staff and that no smoking materials is allowed to be kept in the resident's possession and all will be kept in a smoking cart with the activities department. 4. Ensure Resident 1's Care Plan for Risk of Injury Related to Smoking was updated on 1/20/2025 to reflect the Resident 1 not keeping his smoking materials with him. <p>These failures placed Residents 1, 2 and 3 and other residents in the facility at risk for accidents such as burn from smoking and serious injury due to medication reactions due to alcohol consumption.</p> <p>Findings:</p> <ol style="list-style-type: none"> 1. 1.a. During a review of Resident 1's Admission Record, the Admission Record indicated the resident was initially admitted to the facility on [DATE] and readmitted [DATE] with diagnoses of encephalopathy (a general condition where the brain does not function properly), chronic obstructive pulmonary disease (COPD; a lung condition that causes long-term damage to the airways and air sacs in the lungs leading to difficulty breathing) and schizophrenia (a chronic mental health condition characterized by significant disruptions in thought, perception and behavior). <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 0689</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 Minimum Data Set (MDS - a resident assessment tool), dated 12/19/2024, the MDS indicated the resident was cognitively intact (ability to think, remember, and reason). Resident 1 was dependent (helper does all of the effort) with chair-to-bed transfers, putting on/taking off footwear, needed partial/moderate assistance (helper does less than half the effort) with rolling left and right in bed, going from a sitting position on the edge of the bed to lying down, and upper body dressing (the ability to dress and undress above the waist) and needed set up/clean-up assistance (helper sets up or cleans up while resident completes activity) with eating.</p> <p>During a review of Resident 1's Order Summary Report dated March 2025, Resident 1's Order Summary Report indicated medication orders for:</p> <p>a. Abilify (brand name for an Aripiprazole - an antipsychotic [medication primarily used to treat psychosis - a mental state characterized by symptoms like hallucinations and delusions] medication used to manage and treat schizophrenia) pre-filled syringe (a medical device used to inject medication) 400 milligrams (mg; a unit of measurement) inject 400 mg intramuscularly (into the muscle) every 28 days related to schizophrenia.</p> <p>b. Seroquel (brand name for Quetiapine Fumarate - an antipsychotic medication that treats several kinds of mental health conditions including schizophrenia) 300 mg give 1 tablet by mouth two times a day for schizophrenia.</p> <p>1.b. During a review of Resident 2's Admission Record, the Admission Record indicated the resident was initially admitted to the facility on [DATE] and readmitted [DATE] with diagnoses of paraplegia (a type of paralysis [a condition where a person loses the ability to move or feel in part of all of their body] that affects the lower half of the body) and type two (2) diabetes mellitus (DM2; a chronic [long-term] condition that happens when one has persistently high blood sugar levels).</p> <p>During a review of Resident 2's MDS, dated [DATE], the MDS indicated the resident was cognitively intact. Resident 2 was dependent with chair-to-bed transfers, putting on/taking off footwear and lower body dressing (the ability to dress and undress below the waist), needed partial/moderate assistance with going from a sitting position to lying down in bed, rolling left and right in bed, upper body dressing and needed setup or clean-up assistance with eating.</p> <p>1.c. During a review of Resident 3's Admission Record, the Admission Record indicated the resident was initially admitted to the facility on [DATE] with diagnoses of systemic lupus erythematosus (a chronic autoimmune disease where the body's immune system mistakenly attacks its own tissues and organs causing inflammation and potentially damage) and DM2.</p> <p>During a review of Resident 3's MDS, dated [DATE], the MDS indicated the resident was cognitively intact. Resident 3 needed substantial/maximal assistance (helper does more than half the effort) with lower body dressing, needed partial/moderate assistance with transfers (how resident moves to and from bed, chair, wheelchair, standing position), walking 10 feet, and personal hygiene and needed setup or clean-up assistance with eating.</p> <p>(continued on next page)</p>		

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<p>F 0689</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 Situation, Background, Assessment and Recommendation (SBAR; a structured communication tool used to convey information in a concise and effective manner, particularly in healthcare settings, to ensure clear and efficient communication, especially during critical situations) Communication Form dated 3/9/2025, the SBAR Communication Form indicated Resident 1 was observed in the parking lot drinking an alcoholic beverage.</p> <p>During an interview on 3/12/2025 at 1:51 PM with the Director of Nursing (DON), the DON stated on 3/9/2025 it was reported to her by the Maintenance Assistant (MA) that Resident 1 was drinking alcohol in the facility's parking lot. The DON stated on 3/10/2025 during an IDT meeting with Resident 1, Resident 1 admitted to drinking alcohol but did not disclose how it was obtained.</p> <p>During an interview on 3/12/2025 with Resident 2, Resident 2 stated on 3/9/2025, both he and Resident 3 were outside and saw Resident 1 who was in the smoking area drop a small round bottle of Brand 1 vodka (clear distilled alcoholic beverage typically made from grains or potatoes known for its high alcohol content [15%]) alcohol on the floor.</p> <p>During an interview on 3/12/2025 at 2:37 PM with Resident 3, Resident 3 stated on 3/9/2025, he and Resident 2 were outside by the parking lot and observed Resident 1 in the smoking area holding a small round bottle of Brand 1 vodka while another bottle of the same brand alcohol fell to the ground by Resident 1's wheelchair. Resident 3 stated after Resident 1 went back inside the facility, Resident 2 spoke to the MA who took pictures of the bottles of alcohol and asked MA to report it to the facility's upper management.</p> <p>During an interview on 3/12/2025 at 2:53 PM with Resident 1, Resident 1 stated on 3/9/2025 he went out on pass (OOP; a special permit or permission to temporarily leave a facility for a certain duration and expected to return to the facility) and bought a couple bottles of Brand 1 vodka. Resident 1 stated he drank one and realized his mistake and threw both bottles away stating one was empty and the other was still unopened.</p> <p>During an interview on 3/12/2025 at 3:28 PM with the DON, the DON stated it is not normal for a resident to have liquor in their possession while at the facility unless the resident is cleared and has an order from their physician. The DON stated Resident 1 did not have a physician's order to consume alcohol and stated Resident 1 consuming alcohol is contraindicated (a specific treatment, procedure or medication that is not recommended or should be avoided due to the potential to be harmful or dangerous for a particular individual or situation) since the medications (Abilify and Seroquel) he takes cannot be mixed with alcohol.</p> <p>During an interview on 3/12/2025 at 4:43 PM with MA, MA stated on 3/9/2025 in the facility's parking lot around 2:30 PM, he was asked by Residents 2 and 3 to pick up a drink container that was on the floor. MA stated it was an unopened alcoholic drink round bottle and labeled with Brand 1 vodka and found another empty bottle of Brand 1 vodka that was empty in the trash can in the smoking area. MA stated Residents 2 and 3 stated the alcohol belonged to Resident 1.</p> <p>During a review of the facility's P&P titled Resident Drug & Alcohol Abuse revised 10/24/2022, the P&P indicated its purpose, To provide a safe and drug-free environment for residents while at the facility. The P&P further indicated, The facility has a zero-tolerance policy for the use of alcohol in the Facility or on the grounds of the Facility without a physician order.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a concurrent observation and interview on 3/12/2025 at 4:27 PM with Resident 1 in the hallway, Resident 1 was observed to have a key around his neck. Resident 1 stated that he keeps his own lighter and cigarettes in his room in a locked drawer and that the key around his neck is the key to the locked drawer.</p> <p>During a concurrent interview and record review on 3/12/2025 at 5:27 PM with the DON, the facility's policy and procedure (P&P) titled Smoking revised 3/24/2023 was reviewed. The P&P indicated, All smoking materials will be stored in a secure area to ensure they are kept safe. Based on the individual resident's Smoking Assessment, facility staff shall determine the most appropriate method of secure storage. The DON stated whoever is supervising Resident 1 during his smoking time should also ensure that the resident locks his smoking paraphernalia in his drawer. The DON further stated that she has seen Resident 1 wheel around the facility and sometimes sees his cigarettes and lighter in the resident's pocket t.</p> <p>During an interview on 3/13/2025 at 11:44 AM with the AD, the AD stated Resident 1 is noncompliant with the facility's smoking policy regarding not following the smoking schedule, refusing to wear a smoking apron and not staying in the designated smoking area. AD also stated Resident 1 keeps his own smoking paraphernalia in a locked drawer in his room. The AD further stated facility staff should be the one to handle the smoking paraphernalia such as giving the resident the cigarettes when the resident plan on smoking as well as lighting the resident's cigarette for them.</p> <p>During a concurrent interview and record review on 3/13/2025 at 1:12 PM with the DON, Resident 1's IDT notes dated 10/8/2024 was reviewed. The IDT notes indicated a discussion with Resident 1 regarding their smoking-related violation including Resident 1 providing smoking materials to other residents who are not permitted to smoke in violation of facility policies and the resident consistently disregarding the designated smoking schedule set by the facility. The IDT notes also indicated a follow-up IDT meeting will be scheduled every Friday to assess the resident's compliance with the action plan and determine any further steps. The DON stated the intervention of having a follow-up IDT meeting regarding Resident 1's smoking- related violation every Friday with Resident 1 was not followed.</p> <p>During a concurrent interview and record review on 3/13/2025 at 2:57 PM with the DON, Resident 1's IDT note dated 1/20/2025 was reviewed. The IDT note indicated the team met with Resident 1 to explain the smoking policy and process to ensure safety and supervision is provided. The IDT notes also indicated it was discussed with Resident 1 that the smoking schedule times were established to respect the residents need with smoking and that smoking materials will be continued to be kept in a secure place by facility staff and that no smoking materials are allowed to be kept in the resident's possession, and all will be kept in a smoking cart with the activities department and that Resident 1 agreed to what was discussed. The DON stated Resident 1 is not deemed a safe smoker due to Resident 1's history of noncompliance with the smoking policy and Resident 1 should not keep the resident's own smoking materials in a locked drawer in the resident's room or keep the key and the smoking schedule should be followed, and staff are to monitor those residents to ensure their safety.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a concurrent interview and record review on 3/13/2025 at 3:38 PM with the DON, Resident 1's Resident Smoking Policy Acknowledgement Form dated 4/14/2023 and the facility's P&P titled Smoking revised 3/24/2023 were reviewed. Resident 1's Resident Smoking Policy Acknowledgement Form indicated Resident 1 signed the form indicating Resident 1 acknowledges receiving and understanding the facility smoking policy and agrees to abide by the terms of the policy throughout their stay at the facility. The facility Smoking P&P indicated the response to resident non-compliance with the smoking rules included a first, second and third offense which ultimately would result in the resident losing their smoking privileges. The DON stated since Resident 1 signed their Smoking Policy Acknowledgement Form, the facility's Smoking policy regarding noncompliance should have been followed and that Resident 1's smoking material should not be kept in a locked drawer in the Resident 1's room and the key should be kept by facility staff (did not specify who).</p> <p>4. During a concurrent interview and record review on 3/13/2025 at 2:57 PM with the DON, Resident 1's Risk of Injury Related to Smoking Care Plan dated 2/20/2024 was reviewed. Resident 1's Risk of Injury Related to Smoking Care Plan did not indicated intervention for Resident 1 to stop keeping the resident's smoking materials with the resident. The DON stated the care plan did not reflect the intervention of Resident 1 no longer keeping the resident's smoking materials in a locked boxed in Resident 1's room as discussed in Resident 1's 1/20/2025 IDT note.</p> <p>During an interview on 3/13/2025 at 4:42 PM with the DON, the DON stated Resident 1's Risk for Injury Related to Smoking Care Plan dated 2/20/2024 should have been updated to indicate Resident 1 should not keep his own smoking materials with the resident as discussed in the IDT last 1/20/2025 and since a care plan indicated interventions to ensure the resident is provided with the proper care to ensure their safety.</p> <p>During a review of the facility's P&P titled Care Planning revised 10/24/2022, the P&P indicated, The IDT will revise the Comprehensive Care Plan as needed at the following intervals: To address changes in behavior and care.</p> <p>During a review of the facility's P&P titled Safety of Residents revised 5/1/2023, the P&P indicated, Residents exhibiting unsafe behavior will be reassessed by the IDT when the immediate episode is resolved to determine whether changes to the resident's Care Plan are indicated or if the resident should be transferred to a more appropriate care setting.</p>		