| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 055862 | A. Building<br>B. Wing | 04/16/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Golden Rose Care Center | 1899 N Raymond Ave<br>Pasadena, CA 91103 |

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| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
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| F 0550<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48678<br><br>Based on interview and record review, the facility failed to ensure one of three sampled residents (Resident 1) was treated with dignity and respect when Resident 1 alleged Certified Nursing Assistant 1(CNA1) of throwing the resident's legs on the bed and tossed a pillow at her face on 4/11/2025.<br><br>This deficient practice resulted in Resident 1 verbalizing feeling humiliated and emotionally distressed.<br><br>Findings:<br><br>During a review of Resident 1's Admission Record, the Admission Record indicated Resident 1 was admitted to the facility on [DATE] with diagnosis of left breast cancer (a disease where cells in the breast tissue grow out of control, forming tumors).<br><br>During a review of Resident 1's Minimum Data Set (MDS- resident assessment tool) dated 4/13/2025, the MDS indicated Resident 1 was independent (resident completes the activity by themself with so assistance from a helper) for cognitive (ability to think, reason, and make decisions) skills for daily decision making. The MDS indicated Resident 1 required partial assistance (helper does less than half the effort to lift, hold, or support trunk or arms and legs, but provides less than half the effort) for eating. The MDS indicated Resident 1 required maximal assistance (helper does more than half the effort to lift or hold trunk or limbs and provides more than half the effort) for oral hygiene, upper body dressing, personal hygiene, rolling left and right, sit to lying, and lying to sitting on side of bed. The MDS indicated Resident 1 was dependent (helper does all of the effort, resident does none of the effort to complete the activity) on staff for toileting, showering, and lower body dressing.<br><br>During a review of Resident 1's Care Plan, dated 4/14/2025, the care plan indicated Resident 1 had the potential for emotional distress, skin discoloration and pain on bilateral lower legs related to rough handling by CNA1 during activities of daily living (ADL) care.<br><br>(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<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During an interview on 4/15/2025 at 1:40 PM, with Resident 1 in Resident 1's room, Resident 1 stated that on the night of 4/11/2025, she needed assistance getting perineal hygiene, so she called a staff member to help her. Resident 1 stated CNA1 came in and told her he would come back to help her. Resident 1 stated CNA1 walked in the room and picked up both of her legs and purposely threw them on the bed. Resident 1 stated she thought it was very rude and asked CNA1 if she could have a pillow or a towel, and CNA1 purposely and roughly tossed a pillow at her face. Resident 1 stated she felt helpless and humiliated at the moment and began to cry. Resident 1 stated she did not report this to anyone on that night because she was shocked, however the next day she thought this could happen to someone else, so she decided to report this on 4/14/2025 to the Social Services (SS) staff.<br><br>During an interview on 4/15/2025 at 2 PM with the Director of Nursing (DON), the DON stated CNA1 was a registry (outside agency contracted by the facility that connects licensed nurses or CNAs with individuals, families, or health care facilities that need nursing care) staff hired by an outside agency by the facility. The DON acknowledged the incident and stated that all staff are expected to provide care in a respectful and dignified manner, and that this behavior does not align with facility standards.<br><br>During an interview on 4/16/2025 with the Administrator, the Administrator stated the SS staff reported Resident 1's allegation of abuse on 4/14/2025 and that Resident 1 had been experiencing a lot psychological distress due to various factors such as the allegation of rough handling and her current health placement in hospice (compassionate care for people who are near the end of life provided at the person's home or within a health care facility).<br><br>During a review of the facility's policy and procedure (P&P), titled Resident Rights, dated April 2025, indicated employees are to treat all residents with kindness, respect and dignity and honor the exercise of resident's rights. The facility must promote, maintain, or enhance residents' quality of life regardless of diagnosis, severity of condition or payment source. |

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| F 0583<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Keep residents' personal and medical records private and confidential.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46087<br><br>Based on observation, interview, and record review, the facility staff failed to protect the medical records for six (6) of 14 sampled residents (Resident 4, 5, 6, 7, 8, and 9) when Respiratory Therapist 1 (RT 1, healthcare professional trained to evaluate and treat people who have breathing problems or other lung disorders) left the respiratory therapy (healthcare specialty that focuses in the diagnosis, treatment of breathing disorders) notes unattended on top of the therapy cart located in the hallway where other staff, residents, and visitors walk by.<br><br>This deficient practice had the potential to expose Resident 4, 5, 6, 7,8 and 9's medical records to others and violate the resident's right for privacy and confidentiality (safeguarding the content of information including video, audio, or other computer stored information from unauthorized disclosure without the consent of the resident and/or the individual's surrogate or representative).<br><br>Findings:<br><br>1. During a review of Resident 4's Admission Record, the Admission Record indicated Resident 4 was admitted to the facility on [DATE] with diagnoses that included gastrostomy (a surgical opening fitted with a device to allow feedings to be administered directly to the stomach common for people with swallowing problems), dementia (a progressive state of decline in mental abilities), and major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest).<br><br>2. During a review of Resident 5's Admission Record, the Admission Record indicated Resident 5 was admitted to the facility on [DATE] with diagnoses that included acute respiratory failure (when lungs cannot release enough oxygen into your blood), interstitial pulmonary disease (an umbrella term used for a large group of diseases that cause scarring of the lungs), and shortness of breath.<br><br>3. During a review of Resident 6's Admission Record, the Admission Record indicated Resident 6 was admitted to the facility on [DATE] with diagnoses that included chronic obstructive pulmonary disease (COPD-a chronic lung disease causing difficulty in breathing), gastrostomy and dysphagia (difficulty swallowing).<br><br>4. During a review of Resident 7's Admission Record, the Admission Record indicated Resident 7 was admitted to the facility on [DATE] with diagnoses that included respiratory conditions due to smoke inhalation, bipolar disorder (sometimes called manic-depressive disorder; mood swings that range from the lows of depression to elevated periods of emotional highs) and abnormal posture.<br><br>5. During a review of Resident 8's Admission Record, the Admission Record indicated Resident 8 was admitted to the facility on [DATE] with diagnoses that included shortness of breath, obesity (having too much body fat), and anemia (a condition where the body does not have enough healthy red blood cells).<br><br>6. During a review of Resident 9's Admission Record, the Admission Record indicated Resident 9 was admitted to the facility on [DATE] with diagnoses that included COPD, schizophrenia (a mental illness that is characterized by disturbances in thought), and major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest).<br><br>(continued on next page) |

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| F 0583<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | During an observation on 4/15/2025 at 3:45 PM, a therapy cart located in the hallway was observed. A paper on top of the therapy cart that included Residents 4,5,6,7,8, and 9's name, room number, medication, oxygen, diagnosis and vital signs that included oxygen saturation (level of oxygen found in a person's blood), heart rate, respiratory rate, breath sounds were documented.<br><br>During a concurrent observation, interview, and record review on 4/15/2025 at 3:46 PM with Licensed Vocational Nurse 2 (LVN 2), the therapy cart was observed and the paper on top of the therapy cart was reviewed. LVN 2 stated the therapy cart was being used by RT 1. LVN 2 stated the paper on top of the therapy cart contained the name of Residents 4,5,6,7,8, and 9. LVN 2 stated the paper with the residents' name was left open and unattended. There were other residents and family members walking in the hallway where the therapy cart was located. LVN 2 stated, Anyone walking by can see the resident's medical information. It is the resident's private information and it's HIPAA (Health Insurance Portability and Accountability Act - a federal law that protects resident's health information and gives them more control over how their information is used). LVN 2 stated, We know we are not supposed to leave any paper with resident's information open, It's HIPAA violation that RT 1 walked away from the therapy cart.<br><br>During an interview on 4/16/2025 at 12:33 PM with RT 2, RT 2 stated the paper that contained resident's name should be placed inside the first drawer of the therapy cart and shouldn't be left on top of the cart. RT 2 stated the therapy cart drawer has a lock where in the drawers can't be accessed by unauthorized personnel. RT 2 stated it was important to protect residents' confidentiality and privacy.<br><br>During an interview on 4/16/2025 at 1:05 PM with the Director of Nursing (DON), the DON stated having a paper with resident's name and other information open, where anybody can see it if the staff walk away, is a HIPAA violation. The DON added that all staff are responsible to keep the resident's privacy including keeping papers with resident's information in secure place.<br><br>During a review of Facility's undated Policy and Procedure (P&P) titled, Disclosure of Protected Health Information (PHI), indicated the following:<br><br>Facility Staff should be mindful not to divulge clinical information, such as diagnoses or other personal information in waiting rooms, halls, elevators, the lunchroom, common areas and other public areas.<br><br>Facility Staff will keep medical records secure and confidential.<br><br>Care should be taken to keep a medical record shielded and inaccessible to other residents or to the general public. |

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| F 0755<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46087<br><br>Based on observation, interview, and record review, the facility failed to provide pharmaceutical services to meet the needs of three (3) of 3 sampled residents (Resident 9, 10 and 11) as indicated on the facility policy when Licensed Vocational Nurse 3 (LVN 3) failed to administer Residents 9, 10 and 11's medications within 60 minutes of scheduled time of 9 AM on 4/16/2025.<br><br>This deficient practice had the potential for Residents 9, 10 and 11's health and well-being to be negatively impacted due to unintended consequences, such as decreased effectiveness of the medications and adverse reactions (an unwanted effect caused by the administration of a drug) from the medications.<br><br>Findings:<br><br>1. During a review of Resident 10's Admission Record, the Admission Record indicated Resident 10 was admitted to the facility on [DATE] with diagnoses that included Huntington's disease (a genetic disorder that causes progressive damage to nerve cells in the brain, leading to problems with movement, thinking, and mental health), dementia (a progressive state of decline in mental abilities), and anxiety disorder (a common emotion characterized by feelings of fear, worry, and unease).<br><br>During a review of Resident 10's Minimum Data Set (MDS, a resident assessment tool), dated 1/28/2025, the MDS indicated Resident 10's cognitive skills for daily decision making was modified independence. The MDS indicated Resident 10 required setup or clean-up assistance (helper sets up or cleans up; resident completes activity) with eating. The MDS indicated Resident 10 required partial/moderate assistance (helper does less than half the effort) with oral hygiene, upper body dressing and personal hygiene. The MDS also indicated Resident 10 required substantial/maximal assistance with toileting hygiene, shower/bath, lower body dressing, and putting on/taking off footwear.<br><br>During a review of Resident 10's order summary report, dated 4/16/2025, the report indicated the following active orders:<br><br>a.Buspirone hydrochloride (used to treat certain anxiety disorders) oral tablet 5 milligrams (mg, unit of measurement), give 1 tablet by mouth in the morning for anxiety manifested by worrying thoughts.<br><br>b. Cholecalciferol (a dietary supplement that is used to treat vitamin D [nutrient in maintaining bone health] deficiency) oral tablet, give 2000 international unit (IU, unit of measurement) by mouth one time a day for supplement.<br><br>c. Tetrabenazine (medication to treat chorea [a movement disorder] that is caused by Huntington disease) tablet 12.5 mg, give 1 tablet by mouth two times a day for Huntington's Chorea related to uncontrollable/involuntary jerking (moving abruptly) and twitching (a sudden, involuntary movement).<br><br>d. Zoloft (a drug used to treat depression) tablet 50 mg, give 2 tablets by mouth one time a day for major depressive disorder manifested by verbalization of feeling sad.<br><br>(continued on next page) |

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| F 0755<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | e. Zyprexa (a drug to treat several mental health conditions) oral tablet 5 mg, give 1 tablet by mouth one time a day for psychosis (a state where someone's thinking and perception of reality are significantly distorted, making it difficult to distinguish what is real from what is not) related to Huntington disease manifested by verbalizing thoughts of being hurt by others during activities of daily living (ADLs- activities such as bathing, dressing and toileting a person performs daily).<br><br>During a medication administration observation on 4/16/2025 at 10:02 AM with LVN 3, LVN 3 prepared the following medications:<br><br>Zoloft Tablet 50 MG, 2 tablets<br><br>Zyprexa Oral Tablet 5 MG, 1 tablet<br><br>Tetrabenazine Tablet 12.5 MG 1 tablet<br><br>Buspirone HCl Oral Tablet 5 MG<br><br>During a concurrent interview and observation on 4/16/2025 at 10:05 AM with LVN 3 and Resident 10, LVN 3 stated she will administer the prepared medications to Resident 10 before Resident 10 leaves the room. LVN 5 was observed pushing Resident 10's wheelchair out of the room after administering the medications. LVN 3 stated she will bring Resident 10 to the therapy room.<br><br>2. During a review of Resident 11's Admission Record, the Admission Record indicated Resident 11 was admitted to the facility on [DATE] with diagnoses that included diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing), autistic disorder (a condition that affects how people interact with others, communicate, learn, and behave), and dementia.<br><br>During a review of Resident 11's MDS dated [DATE], the MDS indicated Resident 11's cognitive skills for daily decision making was modified independence. The MDS indicated Resident 11 required setup or clean-up assistance eating. The MDS indicated Resident 11 required partial/moderate assistance with oral hygiene, upper body dressing and personal hygiene. The MDS also indicated Resident 11 required substantial/maximal assistance with toileting hygiene, shower/bath, lower body dressing, and putting on/taking off footwear.<br><br>During a review of Resident 11's medication administration record (MAR, a daily documentation record used by a licensed nurse to document medications and treatments given to a resident) dated 4/16/2025, timed 10:30 AM, the box to indicate medication was administered remained blank for the following medications due at 9 AM:<br><br>a. Aspirin (a medication used to reduce pain, fever, and inflammation) oral tablet chewable 81 mg, give 1 tablet by mouth one time a day for prophylaxis relating to cerebrovascular accident (CVA-stroke, loss of blood flow to a part of the brain).<br><br>b. Cholecalciferol Oral Tablet 25 micrograms (mcg, unit of measurement), give 1 tablet by mouth one time a day for low Vitamin D.<br><br>(continued on next page) |

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| F 0755<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | c. Finasteride (a drug used to reduce the amount of male hormone produced by the body) oral tablet 5 mg, give 1 tablet by mouth one time a day for benign prostatic hyperplasia (BPH, an enlarged prostate gland).<br><br>d. Gabapentin (a muscle relaxant) oral capsule 100 mg, give 1 capsule by mouth one time a day for neuropathy (a condition where nerves are damaged).<br><br>e. Glipizide (a drug to lowers blood sugar) oral tablet 5 mg, give 1 tablet by mouth one time a day for DM.<br><br>f. Multiple vitamin (a supplement) oral tablet, give 1 tablet by mouth one time a day for supplement.<br><br>g. Senna (a drug to treat constipation [having hard, dry stools]) oral tablet 8.6 mg, give 2 tablets by mouth one time a day for constipation.<br><br>h.Docusate sodium (a drug that helps soften the stool) oral capsule 100 mg, give 1 capsule by mouth every morning and at bedtime for bowel management hold for loose stools.<br><br>During a medication administration observation on 4/16/2025 at 10:31 AM with LVN 3, LVN 3 prepared the following medications for Resident 11:<br><br>o Finasteride Oral Tablet 5 MG.<br><br>o Gabapentin Oral Capsule 100 MG.<br><br>o Glipizide Oral Tablet 5 MG.<br><br>o Multiple Vitamin Oral Tablet.<br><br>o Senna Oral Tablet 8.6 MG, 2 tablets.<br><br>o Docusate Sodium Oral Capsule 100 MG.<br><br>During an interview on 4/16/2025 at 10:32 AM with LVN 3, LVN 3 stated she cannot find a bottle of chewable aspirin in medication cart.<br><br>3. During a review of Resident 9's Admission Record, the Admission Record indicated Resident 9 was admitted to the facility on [DATE] with diagnoses that included chronic obstructive pulmonary disease (COPD-a chronic lung disease causing difficulty in breathing), schizophrenia (a mental illness that is characterized by disturbances in thought), and major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest).<br><br>(continued on next page) |

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| F 0755<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | During a review of Resident 9's MDS, dated [DATE], the MDS indicated Resident 9's cognitive (ability to think and reason) skills for daily decision making was modified independence (some difficulty in new situations only). The MDS indicated Resident 9 required substantial/maximal assistance (helper does more than half the effort) with upper body dressing and personal hygiene. The MDS indicated Resident 9 is dependent (helper does all the effort) with eating, oral hygiene, toileting hygiene, shower/bath, lower body dressing, and putting on/taking off footwear.<br><br>During a review of Resident 9's MAR dated 4/16/2025, timed 10:18 AM, the box to indicate medication was administered remained blank for the following medications due at 9 AM:<br><br>a. Cholecalciferol oral tablet 125 mcg, give 1 tablet by mouth one time a day for supplement.<br><br>b.Cranberry extract oral tablet 250 mg, give 2 capsules by mouth, one time a day for supplement.<br><br>c. Culturelle (a supplement) oral capsule, 1 capsule by mouth one time a day for digestive (organs that take in food and liquids) health.<br><br>d. D-Mannose (a supplement) oral capsule 500 mg, give 1 capsule by mouth one time a day for supplement.<br><br>e. Docusate Sodium oral tablet 100 mg, give 1 tablet by mouth one time a day for bowel management.<br><br>f. Folic acid (a supplement) oral tablet 1 mg, give 1 tablet by mouth one time a day for supplement.<br><br>g. Multivitamin-Minerals oral tablet, give 1 tablet by mouth one time a day for wound supplement.<br><br>h. Tamsulosin hydrochloride (a drug used to treat urinary problems) oral capsule 0.4 mg, give 1 capsule orally one time a day for urinating dysfunction. Capsule should be swallowed whole, give 30mins after meals.<br><br>i. Zetia (to treat certain forms of high cholesterol) oral tablet 10 mg, give 1 tablet by mouth one time a day for hyperlipidemia (high cholesterol).<br><br>j. Buspirone hydrochloride (a drug that is used to treat certain anxiety disorders) oral tablet 7.5 mg, give 7.5 mg by mouth two times a day for anxiety manifested by worrying thoughts and hyperventilating (a condition where a person breathes rapidly and deeply) related to anxiety.<br><br>k. Ferrous Sulfate (a supplement) oral solution, give 5 milliliters (ml, unit of measurement) by mouth two times a day for supplement.<br><br>l. Megestrol acetate (a drug to manage weight loss) oral, give 10 ml by mouth two times a day for poor appetite.<br><br>m. Risperidone (a drug used to treat certain mental disorders, such as schizophrenia) oral tablet 1 mg, give 1 tablet by mouth two times a day for schizophrenia.<br><br>(continued on next page) |

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| F 0755<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | During an interview on 4/16/2025 at 10:35 AM with LVN 3, LVN 3 stated she has not given the 9 AM medications to Resident 9 because the electronic MAR keeps signing her out. LVN 3 stated, There's a technical problem.<br><br>During an interview on 4/16/2025 at 12:26 PM with LVN 4, LVN 4 stated failing to administer medication to a resident per the physician's order can lead to medical complications possibly resulting in hospitalization .<br><br>During an interview on 4/16/2025 at 12:50 PM with Registered Nurse (RN), RN stated administering medications can be given one hour early and one hour later than the scheduled time of administration. RN stated if administering medications late or early, the physician should be notified and the justification for the delay should be documented int the progress notes. RN stated medications that are scheduled to be given with food or after meals should be followed because the medication will work better with food or after eating a meal.<br><br>During an interview on 4/16/2025 at 1 PM with the Director of Nursing (DON), the DON confirmed LVN 5 administered Residents 9, 10 and 11's 9 AM medications late on 4/16/2025. The DON stated medications may be administered one hour before or after the scheduled time and should not go beyond that time. The DON stated, it is important to give the medication on time and as ordered by the physician to ensure efficacy of the medications and to avoid possible adverse reactions or side effects that resident can experience. The DON stated when there is a problem in electronic charting, like MAR, the other way to administer medications safely is to have a printed MAR. The DON also added that when LVN 3 is having hard time administering medications on the allotted time, LVN 3 should have asked for help, so another licensed nurse helped her administer the medications.<br><br>During a review of Facility's Policy and Procedure (P&P) titled, Medication Administration-General Guidelines, revised on 12/2029, the P&P indicated the following:<br><br>Medications are administered in accordance with written orders of the prescriber.<br><br>Medications are administered within 60 minutes of scheduled time, except before, with or after meal orders, which are administered based on mealtimes |

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| F 0806<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48678<br><br>Based on observation, interview, and record review, the facility failed to ensure one of two sampled residents (Resident 3) allergy to eggs was clearly communicated and accommodated during meal service.<br><br>This deficient practice had a potential for Resident 3 to suffer complications and to get hospitalized as a result of being served a lunch tray containing mayonnaise (an egg-based product), which potentially caused allergic reaction to Resident 3 on 4/15/2025 and being served breakfast on 4/16/2025 without a lunch tray ticket indicating resident's allergies to eggs.<br><br>Findings:<br><br>During a review of Resident 3's Admission Record, the Admission Record indicated Resident 3 was admitted to the facility on [DATE] with diagnosis of right leg fracture (a break in a bone) following surgery.<br><br>During a review of Resident 3's Minimum Data Set (MDS- resident assessment tool) dated 4/13/2025, the MDS indicated Resident 3 was independent (resident completes the activity by themself with so assistance from a helper) for cognitive skills for daily decision making. The MDS indicated Resident 3 was independent for eating, required supervision (helper provides verbal cues and or touching as resident competes activity. Assistance may be provided throughout the activity or intermittently) assistance to perform oral hygiene, upper body dressing, personal hygiene, rolling left and right, sit to lying, and lying to sitting on side of bed. The MDS indicated Resident 3 required partial (helper does less than half the effort to lift, hold, or support trunk or arms and legs, but provides less than half the effort) assistance for toileting, showring, lower body dressing, putting on footwear and socks, sit to stand, chair to bed transfer, and toilet transfer.<br><br>During a review of Resident 3's Allergy Report dated 4/4/2025, the report indicated Resident 3 had allergies to eggs and latex (natural rubber used in various medical devices and products).<br><br>During a review of Resident 3's Order Summary, the order summary indicated Resident 3 had a regular diet, regular texture, regular consistency.<br><br>During an interview on 4/15/2025 at 2:05 PM with Resident 3 in Resident 3's room, Resident 3 stated she is allergic to eggs, yet she keeps getting served eggs. Resident 3 stated she was served potato salad at lunch on 4/15/2025 at around 12 PM. Resident 3 added she believes it had egg-containing ingredients, maybe mayonnaise, because after she had a couple bites of her food, she felt itchiness in her throat, shortness of breath (sob), and her throat felt constricted. Resident 3 stated she wheeled herself on her wheelchair to the nurse's station and told the charge nurse she was having itchiness in her throat.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 055862 | A. Building<br>B. Wing | 04/16/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Golden Rose Care Center | 1899 N Raymond Ave<br>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.

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| F 0806<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During an interview on 4/15/2025 at 2:12 PM with licensed vocational nurse 1 (LVN1), the LVN1 stated the diet order should reflect Resident 3's allergies to eggs, and the current order failed to indicate Resident 3's allergies. The LVN1 stated it was important to indicate allergies to food items to prevent Resident 3 from being affected by mistakes and allergic reactions.<br><br>During an interview on 4/15/2025 at 2:17 PM with licensed vocational nurse 2 (LVN2), the LVN2 stated she was charge nurse on 4/15/2025 when Resident 3 came to the nurse's station to report itchiness on her throat due to having egg-containing products. LVN2 stated she notified the facility doctor who ordered one time Benadryl (medication to treat allergic symptoms) 25 milligram (Mg- a unit of mass), and to call the paramedics for hospital transfer.<br><br>During an interview on 4/15/2025 with Certified Nursing Assistant 2 (CNA2), CNA2 stated she served Resident 3's lunch tray on 4/15/2025 and noticed the potato salad on the tray but it didn't seem to have mayonnaise or eggs in it. CNA2 stated she did not verify the ingredients with the kitchen staff and gave it to Resident 3.<br><br>During an interview on 4/15/2025 at 2:44 PM with Dietary Kitchen Assistant (DKA), DKA stated the dietary supervisor was on vacation and he had been left in charge on 4/15/2025. DKA stated potato salad was scheduled to be served for lunch on 4/15/2025 and that mayonnaise contains eggs. DKA failed to provide a recipe for the potato salad because he stated he did not have one. DKA stated the kitchen [NAME] follow the recipes listed for each food item served to the residents. DKA stated even though he was in charge that day, he had no way of accessing or modifying any lunch preferences for residents. The DKA stated the process for serving lunch trays is to read the card and serve accordingly.<br><br>During an interview on 4/16/2025 at 10:26 AM with the DKA, DKA stated on the morning of 4/16/2025 for breakfast, Resident 3's lunch ticket did not indicate she was allergic to eggs, but it should indicate her allergies to eggs because that is what the kitchen staff use as a guidance to serve food to residents.<br><br>During an observation on 4/16/2025 at 7:38 AM in Resident 3's room, Resident 3 was served a breakfast tray with a preference card that indicated allergies to latex. No allergies to eggs were noted on the food ticket.<br><br>During an interview on 4/16/2025 with the Director of Nursing (DON), the DON stated Resident 3 had a documented allergy to eggs and this should be reflected on the tray ticket, and all food service staff should be aware of it. The DON stated Resident 3 should not have been served any items containing eggs including mayonnaise since this would place Resident 3 at risk of a severe allergic reaction.<br><br>During a review of the facility's policy and procedure titled, Diet Record Maintenance, the P&P indicated the diet record system will contain the following information to be reflected on the resident's tray card: allergies, and resident food preferences. During a review of the facility's P&P titled, Menus, indicated the Dietary Manager will collaborate with the Registered Dietician to develop menus at least a week in advance and food served should adhere to the written menu. Substitutions should be reviewed by the dietary manager and registered dietitian for appropriateness per the diet order. |

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| | 055862 | A. Building<br>B. Wing | 04/16/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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|---|---|
| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.<br><br>44018<br><br>Based on observation, interview, and record review, the Kitchen Aid (KA) failed to perform hand hygiene after opening the trash lid and prior to food preparation.<br><br>This deficient practice had the potential for the residents to suffer from food borne illness (food poisoning caused by consuming food or beverages that are contaminated with certain infectious or noninfectious agents) which could lead to hospitalization .<br><br>Findings:<br><br>During an observation on 4/14/2025 at 10:15 AM in the kitchen, the KA was observed opening the trash lid and proceeded to cut the zucchini squash on the cutting board without performing proper hand hygiene.<br><br>During an interview on 4/14/25 at 10:16 AM with KA, KA stated she did not perform hand hygiene after touching the trash lid. KA stated staff must always perform hand hygiene before handling food for safety to prevent spread of infections.<br><br>During an interview on 4/14/2025 at 1:12 PM with Administrator (ADM), ADM stated the kitchen staff should perform hand hygiene thoroughly with soap and water before, during, and after food preparation. The ADM stated preparing food without proper hand hygiene increase the risk of foodborne illness to contamination with harmful bacteria and viruses.<br><br>During a review of the facility's policy and procedure (P&P) titled, Hand Hygiene, revised 2/20/2025, the P&P indicated hand hygiene was considered the primary means to prevent the spread of infection and to ensure that all individuals use appropriate hand hygiene while at the facility.<br><br>During a review of the facility's undated P&P titled, Infection Prevention and Control Program, the P&P indicated the purpose of the policy was to ensure the facility established and maintained an Infection Control Program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of disease and infection in accordance with Federal and State requirements. |