

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 05/05/2025
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 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45456</p> <p>Based on interview and record review the facility failed to report an allegation of physical abuse (the willful infliction of injury or trauma to another person resulting physical harm, pain or mental anguish) and verbal abuse (type of psychological/mental abuse that involves the use of oral or written language directed to a victim) on 4/5/2025 for two (2) of 2 sampled residents (Residents 1 and 2) within 2-hour timeframe to the State Survey Agency (SA, where state law provides for jurisdiction in long-term care facilities) and the state ombudsman (advocates for residents of nursing homes, board and care homes and assisted living facilities), in accordance with the facility's abuse policy.</p> <p>This deficient practice had the potential to compromise or impede the protection of Resident 1 and 2 from further abuse, which could affect the residents' emotional and mental wellbeing.</p> <p>Findings:</p> <p>1. During a review of Resident 1's Admission Record, the Admission Record indicated Resident 1 was originally admitted to the facility on [DATE]. Resident 1's diagnoses included acute respiratory failure (occurs when there is not enough oxygen in the blood) with hypoxia (a dangerous condition that happens when your body does not get enough oxygen), anxiety disorder (a disorder characterized by nervousness characterized by a state of excessive uneasiness and apprehension, typically with compulsive behavior [repetitive, persistent, and often uncontrollable actions that a person feels driven to perform] or panic attacks), and hypertension (high blood pressure)</p> <p>During a review of Resident 1's Minimum Data Set (MDS, resident assessment tool), dated 3/5/2025, the MDS indicated Resident 1 had moderately impaired cognitive skills (ability to think, understand, and reason) for daily decision making. The MDS indicated Resident 1 needed supervision or touching assistance (helper provides verbal cues and/or touching/ steadying and/or contact guard assistance as resident completes activity) with eating, oral hygiene, and personal hygiene. The MDS also indicated Resident 1 needed substantial/ maximal assistance (helper does more than half the effort. helper lifts, holds trunk or limbs, and provides more than half the effort) with toileting hygiene, shower, lower body dressing, putting on/ taking off footwear, roll left and right, sit to lying, lying to sitting on side of the bed, sit to stand, chair/bed-to-chair transfer and tub/ shower transfer, and walk 10 to 50 feet. The MDS indicated Resident 1 had coughing or choking during meals or when swallowing medications and had complaints of difficulty or pain in swallowing.</p> <p>(continued on next page)</p>

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0609</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 Nurses Progress Notes (NPN), dated 4/5/2025 at 5:05 PM, the NPN indicated Certified Nursing Assistant 1 (CNA 1) reported to Licensed Vocational Nurse 1 (LVN 1) that while CNA 1 was walking past Resident 1's room, she saw Resident 1's FM (FM 1) hit Resident 1 on the head. NPN indicated LVN 1 went to check on Resident 1 in her room and saw FM1 upset talking to CNA1 regarding the incident that occurred. NPN indicated at 5:45 PM on 4/5/2025, police officers arrived at the facility to make a report. The NPN indicated Resident 1 was placed on 72-hour monitoring for potential emotional distress and was given pain medication.</p> <p>During a review of Resident 1's NPN, dated 4/5/2025 at 5:50 PM, the NPN indicated CNA1 reported to Registered Nurse Supervisor 1 (RNS 1) that FM 1 grabbed Resident 1's hair while he was brushing her teeth. NPN indicated RNS 1 had asked CNA 1 to make a full report for RNS1 to send to the Director of Nursing (DON). RNS 1 informed FM 1 that the DON will meet with him on 4/7/2025 but FM 1 refused and stated he will not come back to the facility until he finds a new skilled nursing facility for Resident 1. The NPN also indicated that the DON was made aware.</p> <p>During a review of Resident 1's NPN, dated 4/5/2025 at 6:18 PM, the NPN indicated two policemen came to the facility and spoke with CNA 1 and Resident 1. The NPN indicated Resident 1 declined the policemen's offer to call paramedics (a person trained to give emergency medical care to people who are injured or ill, typically in a setting outside of a hospital) claiming, She's alright.</p> <p>During an interview on 5/2/2025 at 3:40 PM, CNA 1 stated she observed Resident 1 brushing her teeth and vomiting. CNA1 stated Resident 1 threw up in a plastic container but spilled her vomit on the overbed table. CNA 1 stated she saw FM 1 yelling at Resident 1. CNA1 also stated FM1 pulled Resident 1's hair then pushed the resident's head down towards the over bed table while FM 1 was saying, Look what you did! CNA 1 stated, I told FM 1 to leave Resident 1 alone and that was abuse. FM 1 responded that he was not abusing Resident 1 and told CNA1 to leave them (FM1 and Resident 1) alone. CNA 1 told FM 1 that Resident 1 was under her care, and she would not leave Resident 1 alone with him.</p> <p>During an interview on 5/2/2025 at 3:44 PM, with CNA 1, CNA 1 stated she called the Administrator (ADM) to report the incident, but the ADM did not call back. CNA 1 stated that since RNS 1 did not do an intervention regarding the situation, she decided to call the police department because she does not want Resident 1 to be abused by FM 1.</p> <p>During an interview on 5/2/2025 at 4:05 PM with RNS 1, RNS 1 stated, at 5PM on 4/5/2025, CNA 1 reported an incident about Resident 1's family member. CNA 1 stated, according to the report, FM 1 was assisting Resident 1 to brush her teeth and was spitting in the plastic container, but Resident 1 spilled on the overbed table. RNS 1 stated FM 1 got mad and grabbed Resident 1's hair and screamed at Resident 1.</p> <p>During an interview on 5/2/2025 at 4:16 PM with RNS 1, RNS 1 stated it was not acceptable for a resident to have her hair pulled or be yelled at because these had the potential to cause distress and affect the resident emotionally.</p> <p>During an interview on 5/2/2025 at 4:25 PM with RNS 1, RNS 1 stated she reported the incident to the DON and no further instructions were given.</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 5/2/2025 at 4:28 PM with RNS 1, RNS 1 stated she should have called and reported to the Department of Public Health (CDPH). RNS1 stated it was important to call CDPH, so the survey agency can check the resident and investigate the allegation of abuse.</p> <p>During a concurrent interview and record view on 5/2/2025 at 4:32 PM with RNS 1, the facility's policy and procedure (P&P) titled, Abuse Prevention and Prohibition Program, dated 8/1/2023 was reviewed. The P&P indicated, facility will report allegations of abuse, neglect, mistreatment; immediately, but no later than 2 hours after forming the suspicion if the alleged violation involves abuse. RNS 1 stated, it is important to immediately report abuse to protect the residents from abuse and to prevent further abuse.</p> <p>During an interview on 5/2/2025 at 4:54 PM, the DON stated the facility should have reported the incident with Resident 1 to CDPH because it was an allegation of abuse. The DON added that any allegation of abuse, including physical and verbal abuse, should have been reported to CDPH to protect the residents from any type of abuse. The DON stated, I forgot to report it.</p> <p>During an interview on 5/2/2025 at 4:56 PM, the DON stated, pulling the Resident's hair is physical abuse. The DON stated, FM 1 is always rude, and he always yell at Resident 1. He was always loud.</p> <p>During a concurrent interview and record view on 5/2/2025 at 4:57 PM with DON, the facility's P&P titled, Abuse Prevention and Prohibition Program, dated 8/1/2023 was reviewed. The P&P indicated, facility is committed to protecting residents from abuse by anyone, including but not limited to Facility Staff, other residents, consultants, volunteers, staff from other agencies providing services under arrangement, family members, legal guardians, surrogates, sponsors, friends, and visitors. The DON stated anyone means including family members and visitors should be investigated.</p> <p>During an interview on 5/2/2025 at 5:17 PM with Resident 2, Resident 2 stated Resident 1 was brushing her teeth then vomited on the overbed table. Resident 2 stated she saw FM 1 push Resident 1's head down, almost hitting the overbed table. Resident 2 stated Resident 1 was crying.</p> <p>2. During a review of Resident 2's Admission Record, the Admission Record indicated Resident 2 was originally admitted to the facility on [DATE] with diagnoses which included a history of falling, fracture (broken bones) of left tibia and fibula (two long bones in the lower leg) and left calcaneus (heel bone).</p> <p>During a review of Resident 2's MDS, resident assessment tool), dated 3/5/2025, the MDS indicated Resident 1 had intact cognitive skills for daily decision making. The MDS indicated Resident 2 needed substantial/ maximal assistance (helper does more than half the effort. helper lifts, holds trunk, or limbs, and provides more than half the effort) in toileting hygiene, shower, and lower body dressing. The MDS also indicated Resident 2 needed partial/ moderate assistance (helper does less than half the effort, helper lifts, holds, or supports trunk or limbs but provides less than half the effort) in oral hygiene, upper body dressing, sit to lying, lying to sitting on side of the bed, and chair/bed-to-chair transfer.</p> <p>During an interview on 5/2/2025 at 3:48 PM with CNA 1, CNA 1 stated observed FM 1 yell at Resident 2. CNA 1 stated she reported to the police officer that FM 1 was yelling at her, Resident 1, and Resident 2.</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 5/2/2025 at 5:23 PM with Resident 2, Resident 2 stated, On 4/22/25, FM 1 told me to shut up three times. I felt bad for Resident 1 and myself because I never experienced anyone screaming at me. I get very anxious when I know that FM 1 is coming. I want to go use the bathroom right before he comes in because it makes him upset when I use it when he is here. I get very anxious when FM 1 comes inside the room.</p> <p>During a review of the facility's policy and procedure (P&P) titled, Abuse Prevention and Prohibition Program, revised date 8/1/2023, The P&P indicated,</p> <p>i. Each resident has the right to be free from abuse, neglect, mistreatment, and/or misappropriation of property. The Facility has zero-tolerance for abuse, neglect, mistreatment, and/or misappropriation of resident property. Staff must not permit anyone to engage in verbal, mental, sexual, or physical abuse, neglect, mistreatment, or misappropriation of resident property.</p> <p>ii. The Facility is committed to protecting residents from abuse by anyone, including but not limited to Facility Staff, other residents, consultants, volunteers, staff from other agencies providing services under arrangement, family members, legal guardians, surrogates, sponsors, friends, and visitors.</p> <p>VI. Protection</p> <p>C. If the allegation involves a resident's family member or visitor, such person is not permitted to have unsupervised visits with the resident until the allegation is fully investigated and resolved as unsubstantiated.</p> <p>Reporting / Response</p> <p>D. The Facility will report allegations of abuse, neglect, mistreatment, injuries of unknown source, misappropriation of resident property, or other incidents that qualify as a crime supplementing with the report with Facility Reported Incidents.</p> <p>I. Immediately, but no later than 2 hours after forming suspicion -if the alleged violation involves abuse or results in serious bodily injury to the state survey agency, adult protective services, law enforcement, and the Ombudsman. See AN- 01 -Form G -Crosswalk of abuse Reporting Requirements.</p> <p>iii. No later than 24 hours after forming the suspicion -if the alleged violation (e.g., misappropriation of property, neglect) does not involve abuse and does not result in serious bodily injury to the state survey agency, adult protective services, law enforcement, and the Ombudsman. See AN -01-Form G -Crosswalk of Abuse Reporting Requirements.</p>