

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  07/18/2025
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 0919</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Make sure that a working call system is available in each resident's bathroom and bathing area.</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 0919</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observation, interview, and record review, the facility failed to ensure the call light (used in healthcare facilities as an alerting device for nurses or other nursing personnel to assist a resident when in need) system was functional to alert the staff for three (3) of 3 nursing stations (Stations 1, 2 and 3) from 7/10/2025 until 7/18/2025 based on the facility policy titled, Communication- Call System,. This deficient practice had potential for the delay in care and/or not to meet the residents' needs for assistance and can lead to frustration, falls and accidents. Findings: During a record review of the Maintenance Report (MTR) dated 7/14/2025, the Maintenance Report indicated, on 7/10/2025 at 8 PM, Maintenance Director (MTD) was notified that the call light system at (Stations 1, 2 and 3) was not operational and the troubleshoot was unsuccessful. The MTR also indicated on 7/11/2025 at 4 PM, 7/12/2025 at 2:30 PM, and 7/13/2025 at 3 PM call light system at (Stations 1, 2 and 3) was not operational. During a record review of the Maintenance Logbook Documentation dated 7/2025. The Logbook Documentation did not indicate a test was conducted of the nurse call system from 7/8/2025-7/17/2025. During an observation on 7/14/2025 at 8:45 AM in the Station 1 hallways, the facility's call light system was not working. During an observation on 7/14/2025 at 9:05 AM in Station 3, the facility's call light system was not working. During an observation on 7/14/2025 at 9:15 AM in Station 2, the facility's call light system was not working. During an interview on 7/14/2025 at 9:53 AM with MTD, MTD stated Stations 1, 2 and 3 do not have a functional call light since 7/10/2025. During an interview on 7/14/2025 at 10AM with Environmental Health Consultant (EHC), EHC stated the technicians are having a hard time fixing the call light system. During an observation and interview on 7/15/2025 at 10:05 AM with MTD in Station 2, MTD showed the power supply of the call light system and the transformer (a static electrical machine which transforms electrical power from one circuit to another circuit, without changing the frequency) was disconnected. MTD stated the transformer box was in place inside of the box, but it was already damaged. During an interview on 7/15/2025 at 4:17 PM with the Administrator (ADM), ADM the call light system is not working as of 7/15/2025. During an interview on 7/17/2025 at 4:38 PM with ADM, ADM stated Technician 3 from Company 2 came to the facility at 11AM the call light system was fixed for Rooms 21 through 37 and half of the building is operational and problems with the call lights system are still apparent in Rooms 19 through 20 and room [ROOM NUMBER] that keep causing system to trip. ADM also stated, Rooms 1- to 10 call light system were still not working. During an interview on 7/18/2025 at 3:24 PM with the Director of Staff Development (DSD), DSD stated, call lights are important to the residents because the residents need to use the call light to ask for help from the facility staff and/or something important about their care so they can relay to the staff when the residents have urgent need. DSD stated, if the call light is not working, there will be a delay of care to the residents. During an interview on 7/18/2025 at 3:44 PM with Registered Nurse Supervisor 1 (RNS 1), RNS 1 stated if the residents do not have functional call lights, the residents are not able to get help and/ or assistance they need, and it placed the residents at risk for accidents/ falls. During an interview on 7/18/2025 at 3:45 PM with RNS 2, RNS 2 stated if the Residents call lights were not working, there is a possibility that the residents cannot get help, and they can fall. During an interview on 7/18/2025 at 3:47 PM with the Director of Nursing (DON), the DON stated if the residents did not have a functional call light, there is a possibility that the residents' needs will not be met. The DON also stated the staff will not be able to know if the residents need immediate assistance. During a concurrent interview and record review on 7/18/2025 at 3:50 PM with the DON, the facility's policy and procedure (P&amp;P) titled, Communication- Call System, revised date 10/24/2022 was reviewed. The P&amp;P indicated the resident safety check rounds shall be conducted at least hourly and documented until the primary call system is operable again. During a concurrent interview and record review on 7/18/2025 at 3:51 PM with DON, the facility's P&amp;P titled, Communication- Call System, revised date 10/24/2022 was reviewed. The P&amp;P indicated if the call bell is defective, it will be reported immediately to maintenance and replaced immediately. The DON stated the facility did not have a functional call light for 7 days from 7/11/2025 to 7/18/2025. The policy also indicated call light to be replaced immediately. The DON stated it means the call light should have been fixed right away and did not take 7 days before it was fully functional.</p>		