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	08/19/2025

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. (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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure one of three sampled residents (Resident 1) was provided care and services to maintain good grooming and personal hygiene. This deficient practice resulted in Resident 1 not receiving nail care and had the potential to cause an infection and impact Resident 1's self-esteem (confidence in one's worth or abilities, self-respect).Findings: During a review of Resident 1's admission Record, the admission Record indicated Resident 1 was initially admitted to the facility on [DATE] and was readmitted on [DATE] with diagnoses that included chronic respiratory failure with hypoxia (a condition where the lungs are unable to adequately oxygenate the blood over an extended period), encounter for attention to tracheostomy (a surgically created opening in the windpipe for breathing), and muscle wasting and atrophy (the decrease in muscle mass and strength resulting in weakness and reduced physical function). During a review of Resident 1's Minimum Data Set (MDS- a resident assessment tool), dated 6/10/2025, the MDS indicated Resident 1 was assessed having intact memory and cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decision making. Resident 1 was dependent (helper does all of the effort) with oral/toileting/personal hygiene, shower/bathe self, upper/lower body dressing, roll left and right and sit to lying. During a review of Resident 1's Care Plan, dated 6/4/2025, the care plan indicated Resident 1 had an activities of daily living (ADL) self-care performance deficit related to (r/t) activity intolerance, respiratory failure, intracranial hemorrhage (bleeding within the skull), type 2 diabetes mellitus (DM2- a disorder characterized by difficulty in blood sugar control and poor wound healing), seizure disorder (abnormal electrical activity in the brain that happens quickly), tracheostomy, gastrostomy (a flexible tube surgically inserted through the wall of the abdomen directly into the stomach for feeding, fluid, and medication administration), hypertension (HTN- high blood pressure), congestive heart failure (CHF- a serious condition in which the heart does not pump blood as efficiently as it should), and psychosis (a mental disorder characterized by a disconnection from reality). Resident 1's care plan intervention included to check nail length and trim and clean on bath day and as necessary. Report any changes to the nurse. During an observation on 8/15/2025, at 10:35 AM, in Resident 1's room, Resident 1's right and left fingernails were observed to be painted with dark gray nail polish that only covered the top half of her nail beds. Resident 1's left index (the finger next to the thumb) fingernail was long, and with stain brownish in color. Resident 1's right thumb and index fingernails were also long and stained brown. Resident 1 shook her head from side to side (typically to indicate disagreement, denial, or disapproval) when asked if staff has attempted to provide nail care. Resident 1 frowned and did not answer when asked how it made her feel to have long dirty nails and old nail polish. During an interview on 8/15/2025, at 11:57 AM, with the Director of Rehabilitation (DOR), the DOR stated Resident 1's nails should not be long and dirty. The DOR stated long fingernails can dig into the resident's skin which can cause an infection. The DOR stated Resident 1 was young and having ungroomed nails can cause Resident 1 to feel bad and lower the resident's self- esteem. During a concurrent observation and interview of Resident 1's fingernails, on 8/15/2025, at 1:28 PM, with Certified Nursing Assistant 1 (CNA 1), CNA 1 stated some of Resident 1's fingernails were long and dirty. CNA 1 stated the gray nail polish on Resident 1's fingernails were old and should be removed. CNA 1 stated CNAs were responsible for checking the residents' nails during their shower days and for providing nail care to residents in the facility. CNA 1 stated Resident 1's fingernails should have been cleaned, trimmed, and the resident's nail polish should have been removed as soon as it started looking outgrown. CNA 1 stated long fingernails can cut the skin and cause an infection. CNA 1 stated Resident 1 was alert and young and having long and dirty fingernails can make her feel bad and sad about her condition. During an interview on 8/19/2025, at 11:36 AM, with the Director of Nursing (DON), the DON stated the CNAs were responsible for ensuring that the residents' fingernails are groomed and trimmed. The DON stated the residents can accidentally scratch themselves and get a skin infection if their fingernails are long. The DON stated CNAs should check the Residents' nails daily during ADLs. The DON stated having long and ungroomed fingernails can affect the resident's dignity. During a review of the facility's policy and procedure (P&P) titled, Grooming Care of the Fingernails and Toenails, revised on 6/1/2017, the P&P indicated, nail care is given to clean and keep the nails trimmed.

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. (continued on next page)

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure one of three sampled residents (Resident 2) received treatment and care in accordance with professional standards of practice by failing to notify the physician after Resident 2 refused the resident's Advair (an inhaled medication used daily to prevent and control shortness of breath, chest tightness, and wheezing [a high-pitched, whistling, or raspy sound produced during breathing, usually when air moves through narrowed or blocked airways in the lungs]) on three separate occasions as indicated in the facility's policy and procedure (P&P). This deficient practice placed Resident 2 at risk for experiencing respiratory distress (a condition where a person experienced difficulty breathing, often accompanied by other signs like shortness of breath, rapid breathing, and a pale or bluish tinge to the skin) which could lead to hospitalization. Findings: During a review of Resident 2's admission Record, the admission Record indicated Resident 2 was initially admitted to the facility on [DATE] and was readmitted on [DATE] with diagnoses that included respiratory failure (a serious condition that makes it difficult to breathe on your own), chronic obstructive pulmonary disease with acute exacerbation (COPD- a long term lung disease causing difficulty breathing), and acute combined systolic and diastolic heart failure (CHF- a serious condition in which the heart does not pump blood as efficiently as it should). During a review of Resident 2's Minimum Data Set (MDS- a resident assessment tool), dated 6/27/2025, the MDS indicated Resident 2 was assessed having moderately impaired cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decision making. Resident 2 was dependent (helper does all of the effort) with shower/bathe self, lower body dressing, putting on/taking off footwear, and chair/bed-to-chair transfer. Resident 2 required partial/moderate assistance (helper does less than half the effort) with oral/personal hygiene, toileting hygiene, upper body dressing, sitting to lying, and lying to sitting on side of bed. During a review of Resident 2's Order Summary Report, dated 8/15/2025, the Order Summary Report indicated a physician's order, with a start date or 6/13/2025 for Advair Diskus Inhalation Aerosol Powder Breath Activated 500-50 micrograms (mcg- unit of measurement) 1 puff inhale orally two times a day for COPD, rinse mouth with water (H2O) after use. During a review of Resident 2's Medication Administration Record (MAR) dated 7/1/2025 to 7/31/2025 and 8/1/2025 to 8/31/2025, the MAR indicated Resident 1 refused his Advair on 7/31/2025 at 6 PM, 8/1/2025 at 9 AM, and 8/6/2025 at 6 PM. During a review or Resident 2's Progress Note, dated 7/31/2025, at 7:51 PM, the Progress Note indicated Advair Diskus Inhalation Aerosol Powder Breath Activated 500-50 mcg 1 puff inhale orally two times a day for COPD, rinse mouth with H2O after use, refused three times, risks and benefits explained. The progress note did not indicate Resident 2's primary physician was notified. During an interview on 8/15/2025, at 2:39 PM, with Licensed Vocational Nurse 1 (LVN 1), LVN 1 stated Resident 2 refused to take his Advair on 8/1/2025 at 9 AM and 8/6/2025 at 6 PM. LVN 1 stated she did not notify Resident 2's physician when the resident refused his Advair on 8/1/2025 at 9 AM and 8/6/2025 at 6 PM. LVN 1 stated Resident 2's physician should have been notified when he refused his Advair on 8/1/2025 and 8/6/2025. LVN 1 stated it was important to notify the physician about the refusal to see if the physician wanted to change the medication or monitor Resident 2 closely. During an interview on 8/15/2025, at 3:08 PM, with LVN 2, LVN 2 stated Resident 2 refused to take his Advair on 7/31/2025 at 6 PM. LVN 2 stated she forgot to notify Resident 2's physician after Resident 2 refused to take his Advair on 7/31/2025. LVN 2 stated she did not know what the facility's policy was regarding residents who refuse to take their medications. During an interview on 8/15/2025, at 3:30 PM, with the Director of Nursing (DON), the DON stated she was not notified and aware that Resident 2 refused to take his Advair on 7/31/2025, 8/1/2025, at 8/6/2025. During a follow up interview on 8/19/2025, at 11:36 AM, with the DON, the DON stated Resident 2's physician should have been notified after Resident 2 refused to take his Advair on 7/31/2025 at 6 PM, 8/1/2025 at 9 AM and 8/6/2025 at 6 PM. The DON stated it was important to notify Resident 2's physician to see if the physician wanted order a new medication for Resident 2. The DON stated Resident 2 had the potential to have respiratory distress from not getting his Advair. The DON stated the facility's P&P for medication administration was not followed by LVN 1 and LVN 2. During a review of the facility's P&P, titled, Medication-Administration, revised on 6/1/2017, the P&P indicated the following: The Licensed Nurse will re-approach the resident and attempt to give the medications at a later time, but if resident continues to refuse after one hour, the refused medications will be destroyed. Licensed Nurse will notify the attending Physician and document in the medical record. If the resident repeatedly