

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  09/11/2025
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)
F 0627  Level of Harm - Minimal harm or potential for actual harm  Residents Affected - Few	Ensure the transfer/discharge meets the resident's needs/preferences and that the resident is prepared for a safe transfer/discharge.  (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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<p>F 0627</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on interview and record review, the facility failed to follow its Bed Hold (holding or reserving a resident's bed while the resident is absent from the facility for therapeutic leave or hospitalization) policy for one of two sampled residents (Resident 1) by failing to hold Resident 1's bed for up to seven (7) days while the resident was transferred to the General Acute Care Hospital (GACH) on 9/2/2025. This deficient practice resulted in Resident 1 not being readmitted back when the resident was ready to return to the facility from GACH on 9/7/2025. This had the potential to cause psychosocial harm from displacement and incurred unnecessary hospital days (12 days) at the GACH (from 9/6/2025 to 9/18/2025). During a review of Resident 1's admission Record, the admission Record indicated Resident 1 was initially admitted to the facility on [DATE] with diagnosis which included respiratory failure (condition where there's not enough oxygen or too much carbon dioxide in your body) , dependence on respirator /ventilator (patient cannot breathe sufficiently on their own and requires mechanical assistance for daily respiration) , and persistent vegetative state (individual with severe brain damage appears to be awake but shows no evidence of awareness of their surroundings). During a review of Resident 1's Bed Hold Consent, dated 8/14/2025, the Bed Hold Consent indicated Resident 1 has the option of requesting a 7- day bed hold to keep a bed vacant and available for return to the facility. The Bed Hold Consent was signed by Resident 1's Responsible Party on 8/14/2025. The Bed Hold Consent also indicated confirmation of Resident 1's bed hold provision and GACH transfer on 9/2/2025 at 10:30PM. During a review of Resident 1's Order Summary Report, dated 9/3/2025, the Order Summary Report indicated to transfer Resident 1 to GACH via 911 (the number to call to contact the emergency services) due to tachycardia (a rapid heart rate), and hypertension (high blood pressure) for further evaluation and treatment. The Order Summary Report also indicated Bed hold x (for) 7days. During a review of Resident 1's Progress Notes, initiated 9/2/2025, and timed at 10:55 PM, the Progress Notes indicated Resident 1's heart rate increased to 180 beats per minute (BPM) to 190 BPM and Resident 1's blood pressure was 150/80 millimeters of mercury (mmHg, a unit of pressure). The paramedics (medical professional who specializes in emergency treatment) arrived at the facility on 9/2/2025 at 10:25 PM and transferred Resident 1 to GACH. During a concurrent record review of the facility's census from 9/1/2025 to 9/10/2025 and interview with Licensed Vocational Nurse 1 (LVN 1) on 9/11/2025 at 9:55 AM, LVN 1 stated that according to the census, Resident 1 was occupying a bed on 9/1/2025. LVN 1 added that from 9/2/2025 to 9/4/2025, the census indicated Resident 1 was on bed hold. LVN 1 stated Resident 1's bed was occupied by a new resident on 9/5/2025. LVN 1 stated there was no available bed for Resident 1 on 9/6/2025. During an interview on 9/11/2025 at 10:29 AM with the facility's Marketing admission Staff (MA), MA stated she received a call from the GACH Case Manager on 9/6/2025 stating that Resident 1 was ready to return to the facility. MA stated there was no available bed for Resident 1 on 9/6/2025 since another resident was now occupying Resident 1's previous bed. During an interview on 9/11/2025 at 11:33 PM, the GACH Social Worker (GSW) stated Resident 1 was ready for discharge on [DATE]. GSW stated GACH Case Manager called the facility on 9/6/2025 and informed the MA that Resident 1 was ready to return to the facility on 9/6/2025 but was made aware that the facility does not have an available bed for Resident 1. During a concurrent record review of the facility form titled, admission / Discharge to/ from Report, from 9/1/2025 to 9/10/2025 and interview with Registered Nurse (RN1) on 9/11/2025 at 1:39 PM, RN 1 stated the admission / Discharge to/ from Report indicated Resident 1 was discharged to GACH on 9/2/2025. RN1 also stated the facility did not follow the physician's order for 7-day bed hold because the facility had admitted a new resident in Resident 1's bed. RN 1 stated this was the reason Resident 1 was still in GACH and could not be readmitted back to the facility. During an interview on 9/11/2025 at 2 PM with the Administrator (ADM), the ADM stated the bed reserved for Resident 1 was no longer available because it was given to a new resident on 9/5/2025. ADM also stated that Resident 1's bed should have been reserved for Resident 1 for 7 days, which was from 9/3/2025 to 9/9/2025. The ADM also stated the purpose of the bed hold was to reserve the same bed for 7 days to ensure the residents would have a homelike environment when ready to return to the facility anytime within that period. The ADM further stated if the facility had saved Resident 1's bed, Resident 1 would have gone back to the same room on the day the resident was ready to return to the facility. During a record review of the facility's Policy &amp; Procedure (P&amp;P) titled, Bed Hold, revised 9/1/2023, the P&amp;P indicated upon admission, the facility advises residents/ resident's representative in writing that the facility</p>		