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	11/17/2025

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to develop a resident-centered comprehensive care plan (a care plan developed and implemented to meet the residents' preferences and goals and addresses the residents' medical, physical, mental, and psychosocial needs) for one of two sampled residents (Resident 1) by failing to:1. Develop a comprehensive care plan addressing Resident 1's history of gastrostomy tube (G-tube- a tube inserted through the abdomen that delivers nutrition directly to the stomach) dislodgement from 3/19/2025 to 9/24/2025. 2. Develop a resident-centered comprehensive care plan with specific interventions to prevent Resident 1 from pulling her G-tube on 9/29/2025 This deficient practice resulted in inconsistent implementation of care and can result in Resident 1's G-tube to dislodge. 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 readmitted on [DATE] with diagnoses that included type 2 diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing), gastrostomy malfunction (failure in the G-tube that impairs its normal function of delivering nutrition, fluids, or medications directly to the stomach), and unspecified dementia (a brain disorder that results in memory loss, poor judgment and confusion). During a review of Resident 1's Minimum Data Set (MDS- a resident assessment tool), dated 9/5/2025, the MDS indicated Resident 1 was assessed having severely impaired cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decision making. The MDS also indicated Resident 1 was dependent (helper does all of the effort) with oral/toileting hygiene, shower/bathe self, upper/lower body dressing, personal hygiene, and rolling left and right and the residenthad a feeding tube. During a review of Resident 1's Situation-Background-Assessment-Recommendation (SBAR- a document that provides a framework for communication between members of the health care team about a Resident's condition), dated 4/13/2025, the SBAR indicated, Resident was reported that her (Resident 1) G-tube was dislodged/pulled out but not completely. During a review of Resident 1's SBAR, dated 5/29/2025, the SBAR indicated, G-tube was noted to be dislodged around 2 PM. During a review of Resident 1's SBAR, dated 9/29/2025, the SBAR indicated, Charge Nurse (CN) notified Registered Nurse Supervisor (RNS) the Resident G-tube was dislodge. During a review of Resident 1's SBAR, dated 10/29/2025, the SBAR indicated, G-tube appears to not be anchored securely, G-tube stoma observed to be larger than normal. During a review of Resident 1's Order Summary Report, dated 11/17/2025, the Order Summary Report indicated the a physician order, with a start date of 09/4/2025, for enteral feed order every shift, check tube placement before initiation of formula, medication administration, and flushing tube or at least every (q) 8 hours. During a concurrent observation and interview on 11/17/2025, at 11:50 AM, in Resident 1's room, Resident 1 was awake in bed covered by a blanket with the G-tube feeding pump off. Resident 1 stated she just came back from the hospital but could not state the reason for her hospitalization. Resident 1 was observed pulling the blankets towards her. During a concurrent observation and interview on 11/17/2025, at 12:03 PM, with Certified Nursing Assistant 1 (CNA 1) in Resident 1's room, CNA 1 stated Resident 1 had a tendency to scream and pull her patient gown or linen during diaper change. During an interview on 11/17/2025, at 12:26 PM, with Treatment Nurse (TN), TN stated Resident 1 has pulled Resident 1's G-tube at least two times. TN stated Resident 1 had a strong grip and would grab Resident 1's stomach or G-tube as soon as the resident's abdominal binder was opened during dressing changes. TN stated getting Resident 1 to release her G-tube was like playing tug of war (a game in which two teams pull at opposite ends of a rope). TN stated she would sometimes ask staff to assist during G-tube dressing changes so they can hold Resident 1 and prevent the resident from grabbing the resident's G-tube. During an interview on 11/17/2025, at 12:52 PM, with Licensed Vocational Nurse 1 (LVN 1), LVN 1 stated Resident 1 had a history of pulling her G-tube. LVN 1 stated Resident 1 was confused and would hold on to or pull things. LVN 1 stated LVN 1 does not know if Resident 1 has care plan for G-tube dislodgment. LVN 1 stated care plans were endorsed, created, and updated by the RNS. LVN 1 stated care plans were important because it had goals and interventions on how to fix resident problems. LVN 1 stated care plans were important to prevent problems from recurring. During an interview on 11/17/2025, at 1:05 PM, with LVN 2, LVN 2 stated she has not seen Resident 1's care plan for G-tube dislodgment. During an interview with on 11/17/2025, at 1:26 PM, with Minimum Data Set Nurse (MDSN), MDSN stated Resident 1 has been hospitalized numerous times for pulling her G-tube and G-tube dislodgement. MDSN stated he