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 02/20/2026

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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure one (1) of two (2) sampled residents (Resident 3) was turned every two hours in accordance with the resident's care plan and the facility's policy and procedure (P&P).This deficient practice had the potential for Resident 3 to have a skin tear and develop a pressure injury (painful wound caused as a result of pressure or friction).Findings:During a review of Resident 3's admission Record, the admission Record indicated the Resident 3 was originally admitted to the facility on [DATE] and was readmitted to the facility on [DATE] with the following but not limited to diagnoses of diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing) and protein-calorie malnutrition.During a review of Resident 3's Care Plan with focus on Resident 3 is at risk for further skin breakdown, revised 7/14/2024, the Care Plan indicated to turn and reposition every 2 hours and as needed.During a review of Resident 3's Skin Risk (Braden Scale; evidence-based tool developed to assess a patient's risk of developing pressure injuries) Assessment, dated 1/31/2026, the assessment indicated the resident is at high risk for developing pressure injuries.During a review of Resident 3's Minimum Data Set (MDS - a resident assessment tool), dated 2/5/2026, the MDS indicated the resident was moderately impaired (decisions poor; cues/supervision required) in cognitive (the ability to understand and make decisions) skills for daily decision making. The MDS also indicated Resident 3 was dependent (helper does all of the effort. Resident does none of the effort to complete the activity. Or, the assistance of 2 or more helpers is required for the resident to complete the activity) with oral hygiene, toileting hygiene, shower/bathe self, upper body dressing, lower body dressing, putting on/taking off footwear, personal hygiene, roll left and right, sit to lying, lying to sitting on side of the bed, sit to stand, chair/bed to chair transfer, toilet transfer and tub/shower transfer. The MDS indicated the resident is at risk for developing pressure injuries and has a pressure injury treatment of turning and repositioning program.During an observation on 2/19/2026 at 10:40 AM in Resident 3's room, Resident 3 was noted to be positioned on her right side.During a concurrent observation and interview on 2/19/2026 at 11:12 AM in Resident 3's room, Resident 3's Responsible Party (RP) stated the Certified Nursing Assistants (CNA) will turn her two times during the morning shift, 1 time at 8am and another time at 2pm. Resident 3 was observed to be positioned on her right side.During a concurrent observation and interview on 2/19/2026 at 1:20 PM in Resident 3's room, Resident 3 was observed to be positioned on her right side. Resident 3's RP and roommate both stated the staff has not changed/repositioned the resident since the surveyor went in the room at 10:40 AM.During an interview on 2/19/2026 at 1:25 PM, Licensed Vocational Nurse 1 (LVN 1) stated the resident should be turned every two (2) hours.During an interview on 2/19/2026 at 2:45 PM, Certified Nursing Assistant 1 (CNA 1) stated she changed/repositioned the resident at 8am and at 2pm. CNA 1 stated it is not ok because the resident is supposed to be changed/repositioned every 2 hours to prevent skin issues and pressure injuries.During an interview (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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	on 2/19/2026 at 2:51 PM, Director of Staff Development (DSD) stated the CNAs are supposed to reposition the resident every 2 hours and change the resident every 2 hours or as needed to prevent skin issues and pressure injuries. DSD also stated it is not ok the CNA changed the resident at 8am and then at 2pm because the resident can develop skin issues and pressure injuries.During an interview on 2/20/2026 at 11:30 AM, Director of Nursing (DON) stated the residents should be changed every 2 hours and as needed and repositioned every 2 hours. The policy does not indicate the residents should be changed every 2 hours and as needed but it should indicate every 2 hours and as needed. DON also stated it is to help prevent skin issues and pressure injuries.During a review of the facility's P&P titled Continence Management Guideline, revised 6/2017, the P&P indicated pad/brief change every 2-4 hours.During a review of the facility's P&P titled Positioning and Body Alignment, reviewed 1/1/2026, the P&P indicated change the resident's position every 2 hours.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to follow infection control measures for one (1) of two (2) sampled residents (Residents 4) as indicated on the facility policy by failing to ensure Treatment Nurse 1 (TN 1) performed hand hygiene (washing hands with soap and water for at least 20 seconds, or using alcohol-based sanitizer, to effectively eliminate germs and prevent disease spread) and change gloves after removing a soiled wound dressing for Resident 4.These failures had the potential to result in an increased risk for Resident 4 to develop an infection and spread bacteria, viruses and pathogens (harmful microorganisms) to staff and other residents.Findings:During a review of Resident 4's admission Record, the admission Record indicated the resident was admitted to the facility on [DATE] with the following but not limited to diagnoses of paraplegia (loss of movement and/or sensation, to some degree, of the legs), pressure ulcer of sacral region (sacro-coccyx; the region at the base of the spine, located between the lumbar vertebrae and the tailbone), Stage 4 (Full-thickness skin and tissue loss with exposed muscle, tendon, ligament, cartilage, or bone), bacteremia (the presence of bacteria in the bloodstream, often causing no symptoms but potentially leading to severe, life-threatening sepsis or organ infection if the immune system is overwhelmed), immunodeficiency (a condition where the immune system's ability to fight infectious diseases and cancer is compromised or absent, leading to frequent, severe, or long-lasting infections), and resistance to multiple antimicrobial drugs (occurs when bacteria evolve to survive drugs designed to kill them, making infections difficult to treat and causing serious illness or death).During a review of Resident 4's Minimum Data Set (MDS - a resident assessment tool), dated 12/29/2026, the MDS indicated the resident was severely impaired in cognitive skills for daily decision making. The MDS also indicated the resident was dependent (helper does all of the effort. Resident does none of the effort to complete the activity. Or, the assistance of 2 or more helpers is required for the resident to complete the activity) with oral hygiene, toileting hygiene, shower/bathe self, upper body dressing, lower body dressing and putting on/taking off footwear. The MDS indicated the resident was at risk for developing pressure injuries and had more than one pressure injury.During a review of Resident 4's Physician's Order, dated 1/25/2026, the Physician's Order indicated treatment: sacro-coccyx stage 4 pressure injury; cleanse with normal saline, pat dry, apply collagen powder (a dietary supplement designed to increase the body's natural collagen supply) and Thera honey (line of sterile wound care products designed for managing partial-to-full thickness wounds, burns, and ulcers), then cover with foam dressing every day for 30 days.During a review of Resident 4's Physician's Order, dated 2/20/2026, the Physician's Order indicated treatment: sacro-coccyx stage 4 pressure injury; cleanse with normal saline, pat dry, apply collagen powder and Thera honey, then cover with foam dressing as needed for soiled/displace dressing for 30 days.During a wound care observation on 2/20/2026 at 12:50 PM, Treatment Nurse (TN) was observed taking off Resident 4's soiled dressing and without changing gloves and performing hand hygiene, TN 1 continued with providing wound care to Resident 4.During an interview on 2/20/2026 at 1 PM, TN 1 stated she should have performed hand hygiene and put on a new set of gloves after taking off the dirty/ soiled wound dressing and before continuing with wound care to prevent transmission (the act of transferring something from one spot to another) of microorganisms (a bacterium, virus, or fungus).During an interview on 2/20/2026 at 2:30 PM, the Director of Nursing (DON) stated TN should have changed gloves and performed hand hygiene after removing a dirty/ soiled wound dressing, and before proceeding wound care to prevent the spread of infection.During an interview on 2/20/2026 at 2:45 PM, the facility's Policy and Procedure (P&P) titled Personal Protective Equipment, revised 7/1/2023, was reviewed. The (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	DON stated one time use would be when TN took the soiled dressing off the resident. The DON also stated that after TN took off the soiled dressing, she should have removed the gloves, performed hand hygiene and put on a new set of gloves.During a review of the facility's P&P titled Personal Protective Equipment, revised 7/1/2023, the P&P indicated gloves are used only once and are discarded into the appropriate receptacle located in the room in which the procedure is being performed. The P&P also indicated hands are washed before and after the removing of gloves.