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	03/23/2026

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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to obtain and provide continuous wound treatment for one of three sampled residents (Resident 1) in accordance with the facility policy by failing to: 1) Obtain a wound treatment on the right elbow skin tear (a wound where the top layer of the skin separates from the underlying layer, often caused by friction, shearing or a bump that caused the skin to split, often leaving a flap) from 2/6/2026 to 2/14/2026.2) Provide wound treatments for Resident 1's right elbow skin tear on 1/19/2026, 1/27/2026, and from 2/6/2026 to 2/14/2026. These deficient practices had the potential for delayed healing of Resident 1's right elbow skin tear which could result in complications such as infection and worsening of the wound, thereby negatively affecting the resident's physical comfort and well-being.Findings: During a review of Resident 1's admission Record, the admission Record indicated the resident was initially admitted to the facility on [DATE] and was readmitted on [DATE] with diagnosis that included pressure ulcer (refers to localized damage to the skin and/or underlying soft tissue usually over a bony prominence or related to a medical or other device). During a review of Resident 1's Minimum Data Set (MDS- a resident assessment tool), dated 12/29/2025, the MDS indicated Resident 1 had severe 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 the effort) with oral, toileting and personal hygiene, shower, upper and lower body dressing and putting on/taking off footwear. During a review of the Physician's Order dated, 1/7/2026 at 11:06 AM, the Physician's Order indicated treatment for right elbow skin tear which included cleansing the wound with normal saline (NS-a saltwater solution), pat dry, and apply Xeroform dressing (a sterile, non-stick medicated dressing made of fine mesh gauze to keep wounds moist and speed up healing), then cover with dry dressing daily for 30 days. During a review of Resident 1's Care Plan, dated 3/16/2026, the Care Plan indicated an increase in wound depth of Resident 1's right elbow skin tear on 2/25/2026 with a proposed plan to administer treatment as ordered. During a review of Resident 1's Wound Assessment, dated 2/25/2026, the Wound Assessment indicated wound to the right elbow, measuring 2 centimeters (cm, unit of measurement) by 2.5 (length and width) and depth of 0.4 cm. During a concurrent interview and review of Resident 1's Treatment Administration Record (TAR) and progress notes on 3/23/2026 at 2:43 PM, Treatment Nurse 1 (TN 1) stated Resident 1's TAR indicated wound treatment for the right elbow. TN 1 stated the boxes on the TAR did not have an initial to indicate wound treatment was done by the licensed nurse on 1/19/2026, 1/27/2026, and from 2/6/2026 to 2/14/2026. TN 1 stated Resident 1's Progress Notes did not have a documentation that wound treatment was done on the resident's right elbow on 1/19/2026, 1/27/2026, and from 2/6/2026 to 2/14/2026. TN 1 further stated Resident 1's wound treatment was not consistently provided as ordered which places Resident 1 to be susceptible to infection and had the potential for loss of the right arm if the wound worsens. During an interview on 3/23/2026 at 3:19 PM, Registered Nurse 1 (RN 1) stated treatment to Resident 1's wound on the right elbow should have received continuous treatment, as this allows staff to assess whether the wound is improving and provides a basis for comparison. RN 1 also stated that consistent treatment of Resident 1's right elbow wound is necessary to prevent deterioration and to (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	ensure that any changes are identified and reported to the wound consultant, so the wound can be reevaluated and the treatment modified if needed. RN 1 further stated that if wound treatment is not documented, it is considered not to have occurred. During a concurrent interview and review of Resident 1's Physicians Order and TAR on 3/23/2026 at 4:04 PM, RN 2 confirmed there was no treatment order for Resident 1's right elbow wound RN between 2/6/2026 to 2/14/2026. RN 2 also stated Resident 1 should have been provided with consistent wound treatment on the right elbow between 2/6/2026 to 2/14/2026 to ensure proper healing of the right elbow wound. RN 2 added that all staff caring for the resident including Licensed Vocational Nurses (LVNs), TNs, and RNs are responsible for monitoring the wound treatment, communicating with the physician, and clarifying whether wound treatments should continue. During a review of the facility's Policy and Procedure (P&P) titled, Wound Management, revised 11/1/2017, the P&P indicated to provide a system for the treatment and management of residents with wounds including pressure and non-pressure ulcers. The P&P also indicated that a resident who has a wound will receive necessary treatment and services to promote healing, prevent infection and prevent new pressure ulcers from developing. The P&P further indicated that the attending physician will be notified to advise on appropriate treatment promptly.