

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  04/29/2026
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)		
<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</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 policy to ensure the medical records were complete for one (1) of two (2) sampled residents (Resident 1) by not maintaining the completed Physician Orders for Life-Sustaining Treatment (POLST-a form that allows seriously ill patients to document their end-of-life care wishes) in the resident's medical record. This deficient practice had the potential to create conflict in carrying out the resident's treatment preferences and health care decisions. Findings: During a review of the admission Record, the admission Record indicated Resident 1 was admitted on [DATE] with diagnoses that included chronic obstructive pulmonary disease (COPD- is a progressive lung disease.), dysphagia (difficulty swallowing), and dependence on ventilator (is a life-support machine that breathes for patients unable to breathe adequately on their own due to illness, injury, or surgery.). During a review of the Minimum Data Set (MDS, a standardized assessment and care-screening tool), dated 4/11/2026, the MDS indicated Resident 1's cognitive skill (mental action or process of acquiring knowledge and understanding) for daily decision-making was impaired. The MDS indicated that Resident 1 was dependent (helper does all of the effort, resident does none of the effort to complete the activity) for toileting hygiene, shower/bathe self, and lower body dressing. During an interview with Registered Nurse Supervisor (RN Sup) on 4/28/2026 at 1:11 PM, RN sup stated Resident 1 was transferred to the general acute care hospital (GACH) on 4/14/2026 at 5PM due to chest pain. During an interview on 4/28/2026 at 2:41 PM with Licensed Vocational Nurse 2 (LVN 2), LVN 2 stated the POLST was not available in Resident 1's medical record upon the EMS (Emergency Medical Services, a system providing rapid, pre-hospital care and transport for injuries or illnesses, by calling 911) arrival on 4/14/2026. LVN 2 stated it was important to have the POLST in the resident's chart to know what the resident's wishes were. During a concurrent record review and interview on 4/28/2026 at 4:28 PM with the Administrator (ADM), the ADM stated that Resident 1 had a POLST, dated 4/9/2026 but was not in the resident's medical records. The ADM stated it was important to have the POLST in the chart to provide actionable medical orders and to ensure the resident's care preference was honored during emergency. During a concurrent record review and interview on 4/29/2026 at 10:23 AM with the Nurse Practitioner (NP), the NP stated, On 4/14/2026, I called the daughter because the POLST was not available in the resident's (Resident 1) medical chart. A new POLST was created and signed by me. The NP also stated it was important to have the POLST readily available in the medical chart so that all appropriate and desired care could be provided to the resident. During a review of the facility's Policy and Procedure (P&amp;P) titled, Physician Orders for Life Sustaining Treatment (POLST) dated, 6/1/2017, the P&amp;P indicated the current original POLST will be placed along with a copy of the resident's advanced directive (if he or she has one) in the front section of the resident's medical record. It also indicated that a fully executed, dated copy of the POLST that has been marked COPY, will be retained in the resident's medical record in the advance directive legal section. If the facility has electronic health records, the POLST form will be scanned and placed in the appropriate section of the health care record per facility policy.</p>		

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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