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	06/24/2026

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 complete and document weekly skin assessments for one (1) of two (2) sampled residents (Resident 1) who were assessed to be at high risk for developing pressure ulcer (localized damage to the skin and/or underlying tissue usually over a bony prominence) from 12/29/2025 to 3/2/2026 in accordance with the facility's policy. This deficient practice may result in failure in identifying the development of Resident 1's pressure ulcer.Findings:During a review of Resident 1s admission Record, the admission Record indicated Resident 1 was initially admitted to the facility on [DATE] and was readmitted on [DATE] with diagnoses that included functional quadriplegia (paralysis from the neck down, including legs, and arms, usually due to a spinal cord injury), muscle wasting and atrophy (a decrease in muscle mass, often due to an extended period of immobility) and type 2 Diabetes Mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing). During a review of Resident 1's Minimum Data Set (MDS- a resident assessment tool), dated 2/12/2026, the MDS indicated Resident 1 had severe impairment in 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 toileting hygiene, shower, lower body dressing, and putting/taking off footwear and required substantial/maximal assistance (helper does more than half the effort) with eating, oral and personal hygiene, and upper body dressing. During a review of Resident 1's Braden Scale (a tool that predicts the risk for developing a facility acquired pressure ulcer) dated 2/12/2026, the Braden Scale indicated Resident 1 was high risk for development of pressure ulcers related to being bedfast (confined in bed) and with very limited mobility (ability to move around in bed). During an interview on 6/23/2026 at 3:55 PM, the Minimum Data Set coordinator (MDSC) stated a thorough weekly skin assessment should have been done and documented in Resident 1's medical records from 12/29/2026 to 3/2/2026 to ensure there was no skin breakdown such as pressure ulcer, and so that the resident will receive proper wound treatment and the resident's skin condition would not get worse if there were any skin issues. During an interview on 6/24/2026 at 3:10 PM, the Registered Nurse 1 (RN 1) stated Resident 1 skin assessment should be done weekly by treatment nurses (TNs) because the resident was at risk for pressure ulcer development due to the resident being confined in bed and required repositioning. During an interview on 6/24/2026 at 3:20 PM, the Director of Nursing (DON) stated a thorough skin assessment by the licensed staff should be done and documented in the resident's medical records for all the residents especially Resident 1 who was assessed to be at high risk of skin impairment every week to ensure proper treatment was provided if there are any skin issues or concerns. During a concurrent interview and review of Resident 1's Electronic Medical Record (EMR, an electronic version of the resident's medical history that is maintained by the provider over time) dated from 12/29/2025 to 3/2/2026 with RN 1 on 6/24/2026 at 4:48 PM, RN 1 stated the resident did not have a weekly skin assessment since the resident's readmission on [DATE]. RN 1 also stated the last weekly skin assessment for Resident 1 was done on 7/22/2025. During a review of the facility's Policy and Procedure (P&P) titled, Pressure Ulcer Prevention, dated 1/1/2026, the P&P indicated that the facility would identify (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	residents at risk for pressure ulcers and provide care and services to promote the prevention of pressure ulcer development. The P&P also indicated risk identification and assessment to include the Licensed Nurse to conduct a skin assessment for a resident upon admission, readmission, weekly, and as needed and results of the weekly skin assessment will be documented in the medical record.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review, the facility failed to ensure one (1) of two (2) sampled residents (Resident 1) received labetalol (drug used to lower high blood pressure) 200 milligrams (mg- metric unit of measurement, used for medication dosage and/or amount) in accordance with the physician's order and the resident's physician was notified of the missed doses scheduled on 2/27/2026 and 2/28/2026 at 6 AM in accordance with the facility's Policy and Procedure (P&P) titled, Medication Administration - General Guidelines. This deficient practice resulted to missed medication doses for Resident 1 and had the potential to create medication - related adverse consequences (an unintended, harmful, or unpleasant reaction to a medication, treatment, or therapy) such as elevation and ineffective blood pressure control. Findings:During a review of Resident 1s admission Record, the admission Record indicated Resident 1 was initially admitted to the facility on [DATE] and was readmitted on [DATE] with diagnoses that included hypertensive heart disease (any heart problem caused by long-term, unmanaged high blood pressure). During a review of Resident 1's Care Plan, dated revised on 6/9/2025, the Care Plan indicated Resident 1 has hypertension (HTN, high blood pressure) with a goal for the resident to remain free of complications related to HTN and a proposed plan to give anti-hypertensive medications (drugs used to treat and manage high blood pressure) as ordered. During a review of Resident 1's physician's order dated 1/8/2026 timed at 8:24 AM, the physician's order indicated labetalol 200 mg 1 tablet by mouth every eight (8) hours for HTN The physician's order also indicated to hold for Systolic Blood Pressure (SBP, the maximum pressure in your arteries when your heart beats) below 110 millimeters of mercury (mmHg, standard unit of measurement used to record blood pressure) or heart rate (HR) less than 60 per minute (/min). During a review of Resident 1's Minimum Data Set (MDS- a resident assessment tool), dated 2/12/2026, the MDS indicated Resident 1 had severe impairment in 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 toileting hygiene, shower, lower body dressing, and putting/taking off footwear and required substantial/maximal assistance (helper does more than half the effort) with eating, oral and personal hygiene, and upper body dressing. During a review of Resident 1's Medication Administration Record (MAR - a daily documentation record used by a licensed nurse to document medications and treatments given to a resident) for the resident's labetalol 200 mg for the month of February 2026, the Medication Administration Record indicated the following: 1. A number 5 (hold/see progress notes) and the staff's initial for 6 AM dose on 2/27/2026. 2. A number 9 (other/see progress notes) and the staff's initial for 6 AM dose on 2/28/2026. During a review of Resident 1's nurses progress notes dated 2/27/2026 at 5:58 AM, the nurses progress notes indicated labetalol 200 mg give 1 tablet by mouth every 8 hours for HTN and to hold for SBP less than 110 mmHg or HR less than 60 /min. The nurses' progress notes also indicated awaiting delivery. During a review of Resident 1's nurses progress notes dated 2/28/2026 at 5:39 AM, the nurses progress notes indicated labetalol 200 mg give 1 tablet by mouth every 8 hours for HTN and to hold for SBP less than 110 mmHg or HR less than 60 /min. The nurses' progress notes also indicated waiting for delivery. During a concurrent interview and review of records with the Director of Nursing (DON) on 6/23/2026 at 4:25 PM, Resident 1's MAR dated 2/27/2026 and 2/28/2026 were reviewed. The DON stated Resident 1's MAR did not indicate labetalol was given to Resident on 2/27/2026 and 2/28/2026 for the 6 AM dose. During an interview on 6/24/2026 at 2:50 PM, the facility's Pharmacist (Pharm 1 Resident 1's labetalol 200 mg was dispensed on 2/25/2026 for a 14-day supply for the resident and was delivered on and received by the facility on 2/27/2026 at 6:59 pm with the facility staff signature of receipt. Pharm 1 also stated the pharmacy had delivered all three (3) labetalol bubble packs (a personalized packaging system that organizes pills into individual plastic (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	compartments or bubbles) which is for the morning, afternoon and night all at the same time because they all have the same prescription number. During an interview on 6/24/2026 at 3:10 PM, Registered Nurse 1 (RN 1) stated a check mark besides the staff initials in the MAR would indicate the medication was administered. RN 1 also stated 5 or 9 code means the medication was not administered and the reason documented in the resident's progress notes. During an interview on 6/24/2026 at 4:08 PM, RN 2 stated she was waiting for Resident 1's labetalol 200 mg bubble pack from the pharmacy for the resident's 6 AM doses on 2/27/2026 and 2/28/2026. RN 2 also stated she was unable to administer Resident 1's labetalol on 2/27/2026 and 2/28/2026 because the medicine was not available. RN 2 further stated she should have notified Resident 1's physician with the missed doses to prevent worsening of the resident's high blood pressure and/ or other adverse consequences of the missed dose. RN 2 also stated she should have checked Resident 1's BP to ensure the residents BP was not elevated the morning of 2/27/2026 and 2/28/2026 that might require a transfer to General Acute Care Hospital (GACH). During a review of the facility's P&P titled, Medication Administration - General Guidelines, dated 1/2022, the P&P indicated that the medications are administered in accordance with the written orders of the prescriber. The P&P also indicated if consecutive doses of a vital medication are not available the physician is notified and nursing documents the notification and the physician's response.